93-429

No. _____

Supreme Court, U.S.
FILED
SEP 16 1993
OFFICE OF THE CLERK

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1993

EPISCOPAL HOSPITAL, ET AL.,

Petitioners,

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR
THE DISTRICT OF COLUMBIA CIRCUIT

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Mark H. Gallant
Counsel of Record

Ellen N. Berman

WOLF, BLOCK, SCHORR AND
SOLIS-COHEN
12th Floor, Packard Building
S.E. Corner 15th & Chestnut
Streets
Philadelphia, PA 19102-2678
(215) 977-2000
Attorneys for Petitioners

QUESTION PRESENTED

Whether Congress required the Secretary to apply the adjustment provisions contained in 42 U.S.C. §1395ww(b)(4)(A) in calculating the hospital-specific portion of Medicare reimbursement for the four year transition period under the Prospective Payment System in order to eliminate known distortions in such costs.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iii
OPINIONS BELOW	1
JURISDICTION	1
STATUTES AND REGULATIONS	2
STATEMENT OF THE CASE	2
A. Introduction	2
B. Statutory and Regulatory Background	3
C. Proceedings Below	6
REASONS FOR GRANTING THE PETITION	10
I. THE DECISION BELOW CREATES A CONFLICT AMONG THE CIRCUITS ON AN IMPORTANT QUESTION OF LAW	10
II. THE DECISION BELOW IS MANIFESTLY INCORRECT: CONGRESS PLAINLY REQUIRED THE SECRETARY TO APPLY THE TEFRA ADJUSTMENTS IN DETERMINING THE HOSPITAL-SPECIFIC PORTION OF MEDICARE REIMBURSEMENT	12
III. THE DECISION BELOW MISAPPLIES CHEVRON AND ITS PROGENY AND ENDORSES A STANDARD OF REVIEW THAT FRUSTRATES CONGRESSIONAL INTENT	17
CONCLUSION	22

TABLE OF AUTHORITIES

Cases	*Page*
Andrus v. Glover Construction Co., 446 U.S. 608 (1980)	14
Board of Governors of the Federal Reserve System v. Dimension Financial Corp., 474 U.S. 361 (1986)	17
Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988)	19
Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984)	12, 17, 18
Community Hospital of Chandler, Inc. v. Sullivan, 963 F.2d 1206 (9th Cir. 1992)	10, 11, 13, 20
FEC v. Democratic Senatorial Campaign Committee, 454 U.S. 27 (1981)	17
General Care Corp. v. Sullivan, No. 92-1326 (D.D.C.)	11
Georgetown University Hospital v. Bowen, 862 F.2d 323 (D.C. Cir. 1988)	4, 5, 18, 20
Good Samaritan Hospital v. Shalala, ___ U.S. ___, 113 S. Ct. 2151 (1993)	10, 19, 21
Greenville Hospital System v. Bowen, No. 6:85-337-3 (D.S.C. 1986), Medicare & Medicaid Guide (CCH) ¶35,880, *vacated as a condition of settlement*, ¶36,072 (D.S.C. 1986)	11, 19, 20
Hospital Corporation of Tennessee v. Sullivan, No. 92-1325 (D.D.C.)	11
HCA Services of Texas v. Sullivan, No. 92-1324 (D.D.C.)	11
Harmarville Rehabilitation Center, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania, PRRB Hearing Dec. No. 93-D42 (5/20/93), Case No. 85-1135, *reprinted in* Medicare & Medicaid Guide (CCH) ¶41,558	9

	Page
Hillsborough County Hospital Authority, et al., v. Shalala, 91-12-CIV-T-21 (M.D. Fla.)	11
INS v. Cardoza-Fonesca, 480 U.S. 421 (1987)	20
K Mart Corp. v. Cartier, Inc., 486 U.S. 281 (1988)	17
Motor Vehicle Manufacturers Ass'n v. State Farm Auto Ins. Co., 463 U.S. 29 (1983)	19
New York City Health and Hospitals Corp. v. Parales, 954 F.2d 854 (2d Cir.), *cert. denied*, ____ U.S. ____, 113 S. Ct. 461 (1992)	18
Newport Hospital and Clinic, Inc. v. Sullivan, C.A. No. 88-2490-LFO (D.D.C. September 24, 1990), Medicare & Medicaid Guide (CCH) ¶38,844, *Secretary's appeal voluntarily withdrawn* (1991)	11, 13, 20
Nyack Hospital v. Sullivan, No. 92-0455 (D.D.C.)	11
Okeechobee Hospital v. Sullivan, No. 92-1323 (D.D.C.)	11
Redbud Hospital District v. Heckler, No. C-84-4382-MHD (N.D. Cal. 1984), Medicare & Medicaid Guide (CCH) ¶34,085 *vacated on other grounds*, 473 U.S. 1308 (1985)	11
Sacred Heart Medical Center v. Sullivan, 958 F.2d 537 (3d Cir. 1992)	Passim
Securities Industry Ass'n v. Board of Governors of the Federal Reserve System, 468 U.S. 137 (1984)	17, 19
Sunshine Health Systems v. Bowen, 809 F.2d 1390 (9th Cir. 1987)	10, 20
The Methodist Hospital, et al. v. Sullivan, C.A. No. 90-1871-GAG (D.D.C. September 20, 1991), Medicare & Medicaid Guide (CCH) ¶39,627 *appeal pending*, D.C. Cir. Nos. 91-5404 and 92-5034	10, 11, 13
Udall v. Tallman, 380 U.S. 1 (1985)	17
Washington Hospital Center v. Bowen, 795 F.2d 139 (D.C. Cir. 1986)	5, 18

	Page
Statutes	
28 U.S.C. §1254(1)	1
42 U.S.C. §1395d(1)(a)	6
42 U.S.C. §1395q(d)	6
42 U.S.C. §1395x(v)	3
42 U.S.C. §1395ww(a)	1, 13, 14
42 U.S.C. §1395ww(b)	1, 3, 12
42 U.S.C. §1395ww(b)(3)(A)	Passim
42 U.S.C. §1395ww(b)(4)	6
42 U.S.C. §1395ww(b)(4)(A)	Passim
42 U.S.C. §1395ww(b)(6)	6
42 U.S.C. §1395ww(d)(1)	5, 6
42 U.S.C. §1395ww(d)(1)(A)	Passim
42 U.S.C. §1395ww(d)(1)(C)	5
42 U.S.C. §1395ww(d)(5)	15
42 U.S.C. §1395ww(d)(5)(A)-(H)	15
42 U.S.C. §1395ww(d)(5)(E)(i)	6
42 U.S.C. §1395ww(d)(5)(I)	9, 16
42 U.S.C. §1395oo(f)(1)	8
Pub. L. No. 97-248, 96 Stat. 324 (1982)	3
Pub. L. No. 99-272 §9102(b), 100 Stat. 85155 (1986)	5
Pub. L. No. 100-360, 102 Stat. 683 (1988)	9
Regulations	
42 C.F.R. §403.200 *et seq.*	6
42 C.F.R. §405.463	19
42 C.F.R. §405.470(b)(2)(ii) *redesignated* 42 C.F.R. 412.2(b)(2), 412.42(a)	6, 8
42 C.F.R. §409.60	6
42 C.F.R. §409.61	6
42 C.F.R. §409.65(a)	6

	Page
42 C.F.R. §409.68	6
42 C.F.R. §412.2	1, 6
42 C.F.R. §412.2(b)(2)	7
42 C.F.R. §412.42(a)	7
42 C.F.R. §412.70	1
42 C.F.R. §412.71	1, 20
42 C.F.R. §412.71(a)	6
42 C.F.R. §412.71(b)(5), (6), (7) *formerly* 42 C.F.R. 405.474(b)(2)	8
42 C.F.R. §412.71(c)(1)(ii)	8
42 C.F.R. §412.71(d)	8
42 C.F.R. §412.72	1, 20
42 C.F.R. §412.72(a)	8
42 C.F.R. §412.73	1
42 C.F.R. §412.73(a)	6
42 C.F.R. §413.40	3, 19
42 C.F.R. §413.40(f)-(g)	4

Federal Register

57 Fed. Reg. 23660 (June 4, 1992)	10
53 Fed. Reg. 38520 (Sept. 30, 1988)	9
51 Fed. Reg. 8208, 8210 (Mar. 10, 1986)	19
49 Fed. Reg. 279 (Jan. 3, 1984)	6
49 Fed. Reg. 261 (Jan. 3, 1984)	5, 19
48 Fed. Reg. 39752, 39818 (Sept. 1, 1983)	6

Legislative History

H.R. 1900, Rep. No. 98-25, Part 1, 98th Cong. 1st Sess.	15
H.R. Conf. Rep. No. 98-47, 98th Cong. 1st Sess. 182, *reprinted in* 1983 U.S.C.C.A.N. 404, 471-72	5, 15
H.R. Rep. No. 100-105, 100th Cong., 2d Sess., *reprinted in* 1988 U.S.C.C.A.N. 803, 813	9

Page

H.R. Rep. No. 98-25, 98th Cong., 1st Sess. 132, 136, *reprinted in* 1983 U.S.C.C.A.N. 355 ..... 4, 5, 15

S. Rep. No. 98-23, 98th Cong., 1st Sess. 49-50, 53, *reprinted in* 1983 U.S.C.C.A.N. 143, 189-90, 193 5, 6

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1993

No. _____

EPISCOPAL HOSPITAL, ET AL.,

Petitioners,

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Episcopal Hospital, et al. ("petitioners") respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals (Appendix 1a)[1], is reported at 994 F.2d 879 (D.C. Cir. 1993) (Sentelle, C.J.). The opinion and orders of the District Court (App. 11a) are unreported. The opinions of the Provider Reimbursement Review Board ("PRRB") (App. 28a, 31a, 34a), are unreported.

JURISDICTION

The judgment of the Court of Appeals was entered on June 18, 1993 (App. 10a). The jurisdiction of the Court is invoked under 28 U.S.C. 1254(1).

---

1 Pages in the Appendix are cited as "App. a."

STATUTES AND REGULATIONS[1]

The following statutes and regulations are set forth in the Appendix to the Petition:

42 U.S.C. §1395ww(a)	42 C.F.R. §412.70
42 U.S.C. §1395ww(b)	42 C.F.R. §412.71
42 U.S.C. §1395ww(d)	42 C.F.R. §412.72
42 C.F.R. §412.2	42 C.F.R. §412.73

STATEMENT OF THE CASE

A. Introduction

Petitioners are seven non-profit Philadelphia area hospitals.[2] They challenge the refusal of the Secretary of Health and Human Services ("HHS") to adjust the allowable base-year costs used to calculate the "hospital-specific portion" (or "HSP") of their Medicare rates throughout the four-year "transition period" leading to payments based on a fully federal rate under the Prospective Payment System ("PPS"). Congress mandated a transition period, during which each participating hospital's payment rates are based in substantial part on its own costs incurred during a pre-PPS "base year." The purpose of the transition period was to minimize financial disruption resulting from a change to PPS from the prior reimbursement system, under which hospitals had for two decades been retrospectively reimbursed Medicare's share of the costs they actually incurred. Petitioners specifically sought upward adjustments of their base-year operating costs to account for certain Medicare coverage changes initiated after the base-year, which rendered their hospital-specific base payment amounts non-comparable with operating costs during the transition period.

---

2. *Rule 29.1 Statement:* Parties to the action include: Episcopal Hospital (no parent company; subsidiaries include Episcopal Heart Institute, Episcopal Billing Corporation and Episcopal Cardiovascular Corporation), Presbyterian-University of Pennsylvania Medical Center (no parent company; no subsidiaries), Thomas Jefferson University Hospital (no parent company; no subsidiaries), The Graduate Hospital (parent company Graduate Health System; no subsidiaries), Mercy Catholic Medical Center (parent company Mercy Health Corporation has two divisions: Fitzgerald Mercy Hospital and Misericordia Hospital; no subsidiaries), Medical College of Pennsylvania (parent company Allegheny Health, Education and Research Foundation; no subsidiaries), Metropolitan Hospital (no parent company; no subsidiaries).

The refusal to adjust the base-year costs in formulating the hospital-specific rates runs afoul of the statute and legislative history, embodies an about face by the Secretary concerning the availability of such adjustments in determining the PPS hospital-specific rates with far reaching implications, and has deprived petitioners of approximately two million dollars of reimbursement for care rendered to Medicare recipients. In upholding the Secretary's restrictive approach, the lower court has aligned itself with the Third Circuit in direct conflict with two prior decisions of the Ninth Circuit and a uniform body of district court decisions. These factors warrant a definitive ruling by this Court.

B. Statutory and Regulatory Background

The Medicare Program established by Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq.*, pays for covered medical services provided to eligible aged and disabled persons. It encompasses inpatient hospital insurance coverage, under "Part A," and supplemental medical insurance coverage (for physicians' services, tests and other ancillary services), under "Part B." This case involves petitioners' reimbursement under Part A.

Prior to October of 1983 hospitals were reimbursed by Medicare retrospectively, based upon each hospital's allowable costs, under a "reasonable cost reimbursement system." 42 U.S.C. §1395x(v). In 1982, Congress, enacting the Tax Equity and Fiscal Responsibility Act ("TEFRA"), modified somewhat the payment regime to contain Medicare costs. Pub. L. No. 97-248, 96 Stat. 324 (1982), *codified in part* in 42 U.S.C. §1396ww(b). While TEFRA left the basic retrospective, cost-reimbursement structure of Part A intact, it tied each hospital's annual rate of payment increase to a "target amount," defined in 42 U.S.C. §1395ww(b)(3)(A) (1988) as the hospital's allowable costs of inpatient hospital services for the preceding cost reporting period (or base-year), increased by a specified percentage in each succeeding cost reporting period. Hospitals with costs exceeding the prescribed rate-of-increase above the base-year target amounts were subject to a penalty. 42 U.S.C. §1395ww(b)(1)(A); 42 C.F.R. §413.40 (1992).

In establishing this framework, Congress recognized that coverage changes and other disparities might affect the essential comparability of allowable costs incurred during and after the TEFRA base-year. TEFRA accordingly directs the Secretary to provide

for exemptions from and exceptions and adjustments to the TEFRA payment amount "where events beyond the hospital's control or extraordinary circumstances, . . . create a distortion in the increase in costs for a cost reporting period . . ." 42 U.S.C. §1395ww(b)(4)(A).[3] As part and parcel of this target amount formulation, a conforming regulatory mechanism was implemented for adjusting the hospital-specific base-year costs to maintain comparability of allowable operating costs before and after the base-year. 42 C.F.R. §413.40(f)-(g).

In 1983 Congress supplanted this payment system as to most general hospitals with PPS.[4] Under PPS, payments for operating costs — the largest portion of Part A reimbursement — are set in advance based on a standardized per admission rate which is multiplied by a weighing factor depending on the diagnosis related group ("DRG") into which the admission falls. *See Georgetown University Hospital v. Bowen*, 862 F.2d 323, 324 (D.C. Cir. 1988). This "radically new" system was "designed to reform the financial incentives hospitals face" by "promoting efficiency." *Id.* at 324, *quoting* H.R. Rep. No. 98-25, 98th Cong., 1st Sess. 132, *reprinted in* 1983 U.S.C.C.A.N. 143, 219, 315. At the same time, "Congress recognized that implementation of the new PPS threatened severe financial dislocations in the health care delivery system." *Id.* To "minimize disruption that might otherwise occur because of sudden change," Congress, over the Secretary's objection, included a three-year transition period, later extended to four years, during which a hospital's prospective payment would be based on an increasing federal portion, unrelated to individual

---

3. 42 U.S.C. §1395ww(b)(4)(A) states more fully:

> The Secretary shall provide for an exemption from or an exception and adjustment to, the method under this subsection [1395ww(b)] for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured)* * *

4. The TEFRA cost limit system continues to govern inpatient hospital reimbursement for hospitals and hospital units that are exempt from PPS, e.g., psychiatric and rehabilitation hospitals.

hospital costs, and a hospital-specific portion (or "HSP").[5] *Id.*, *quoting* S. Rep. No. 98-23, 98th Cong., 1st Sess. 53, *reprinted in* 1983 U.S.C.C.A.N. 143, 193; *Washington Hospital Center v. Bowen*, 795 F.2d 139, 142 (D.C. Cir. 1986).

In 42 U.S.C. §1395ww(d)(1), Congress directed the Secretary to use each hospital's TEFRA "target amount," as defined in §1395ww(b)(3)(A), in calculating the HSP. This amount uses allowable operating costs of inpatient services during the preceding 12-month cost reporting period. 42 U.S.C. §1395ww(b)(3)(A); *Georgetown*, 862 F.2d at 324. It was to be adjusted for inflation and otherwise updated during the transition period. §1395ww(d)(1).

The HSP component of the DRG rate serves as a proxy for reimbursable costs incurred by particular hospitals, but of necessity, had to be constructed in advance of the transition period. As noted above, §1395ww(b)(4)(A) provides for mandatory adjustments of base-year costs in advance of setting the target amount in order to neutralize documented disparities in allowable operating costs during and following the relevant base-year which are attributable to events beyond a hospital's control or extraordinary circumstances. In the preamble to the final regulations implementing PPS, the Secretary acknowledged expressly that §1395ww(b)(4)(A) was incorporated into the HSP-setting process so that the HSP will, as closely as practicable, be representative of allowable hospital-specific costs going forward. 49 Fed. Reg. at 261 (Jan. 3, 1984). Additionally, in enacting PPS the Conference Committee directed the Secretary to "use estimates to adjust some portions of the hospital's base year experience to make it comparable to inpatient operating costs that will be paid under the prospective system — e.g., FICA taxes that would have been paid if the hospital had been in the social security system . . . ." H.R. Conf. Rep. No. 98-47, 98th Cong., 1st Sess. 181-82, *reprinted in* 1983 U.S.C.C.A.N. 404, 471-72.[6]

5. The HSP controls reimbursement to a significant degree over the course of the transition period, gradually declining from 75% of the total DRG rate until the blended rate is replaced by a fully federal rate in the fifth year of PPS. 42 U.S.C. §1395ww(d)(1)(C), *as amended* by Pub. L. No. 99-272 §9102(b), 100 Stat. 85155 (1986).

6. The Senate Committee similarly recognized that certain services covered by Medicare Part A under PPS were not covered as allowable costs during the base-year, and that various "exceptions and adjustments" were required to take such

C. Proceedings Below

In general terms, the HSP is derived by dividing a numerator, consisting of total "allowable" operating costs for Medicare patients — i.e., those costs reimbursable under Part A — in the base-year, by a denominator consisting of the total number of Medicare patients "discharged" during the base-year, to yield a base per-discharge cost. 42 U.S.C. §1395ww(b)(4) and (d)(1); 42 C.F.R. §§412.2, 412.71(a), 412.73(a). Before and after PPS, Medicare beneficiaries were "covered" for 90 days of Part A hospital inpatient services annually per "spell of illness." 42 U.S.C. §1395d(1)(a); 42 C.F.R. §§409.60, 409.61. Under cost-based reimbursement, hospitals received reimbursement for allowable operating costs of services provided to Medicare patients only to the extent the services were provided on days for which the patients had Medicare coverage. 42 U.S.C. §1395q(d). If coverage expired after at least one covered day of a hospital stay hospitals were entitled to directly bill the patients or their private "Medigap" insurers for the additional amounts due for any days of hospitalization following the exhaustion of Medicare coverage. 42 C.F.R. §§409.61, 409.65(a), 409.68; 49 Fed. Reg. 279 (Jan. 3, 1984); 42 C.F.R. 403.200 *et seq.* In implementing PPS, the Secretary modified the Medicare coverage rules by discretionary regulation so that, henceforth, the entirety of any inpatient hospital stay involving at least one day of Medicare eligibility would be treated as a fully "covered" stay under Part A, for which the PPS payment itself would necessarily represent payment in full.[7]

---

situations into account because "the prospective payment is intended to be payment in full for all covered items and non-physician services to hospital inpatients." S. Rep. No. 98-23, 98th Cong., 1st Sess. 49-50, *reprinted in* 1983 U.S.C.C.A.N. 189-190. Adjustments for some disparities, which were clearly anticipated by Congress in advance, were specifically delineated. *See, e.g.*, 42 U.S.C. §1395ww(b)(6) (FICA taxes which were added after the base-year due to "bundling" of usage-costs of employed hospital staff who fomerly billed separately and outside the scope of Part A); §1395ww(d)(5)(E)(i) (adjustments for ancillary hospital services previously covered under Part B of Medicare). Other such "distortion" causing events and Part A coverage changes were not identified by Congress specifically, but were nevertheless anticipated categorically and categorically made subject to a mandatory adjustment through the incorporation of §1395ww(b)(4)(A).

7. 42 C.F.R. §405.470(b)(2)(ii)(1984), 48 Fed. Reg. 39752, 39818 (Sept. 1, 1983), *redesignated* 42 C.F.R. §§412.2(b)(2), 412.42(a).

Consequently, operating costs that were not recognized in the base year, solely because they were incurred after the exhaustion of Medicare coverage during an initially covered stay, were not taken into account in determining the HSP.[8] Because the costs of such stays would henceforth be deemed allowable costs and solely and exclusively reimbursed by DRG payments, 42 C.F.R. §§412.2(b)(2) and 412.42(a), petitioners timely requested adjustments of their HSPs to prevent the loss of reimbursement for these hospital-specific costs throughout the course of the transition period. Relying on actual filed cost-report data, and prior to the start-up of PPS, each petitioner identified otherwise reimbursable base-year costs (ranging from approximately $41,000 to $355,000) attributable to and excluded solely because they attached to post-coverage exhaustion days of initially covered stays, and requested its fiscal intermediary to adjust its average per discharge base year costs to take its "lost" costs into account in calculating the HSP.[9] Petitioners assumed *inter alia* that the TEFRA adjustment provisions contained in 42 U.S.C. §1395ww(b)(4)(A) had been incorporated into PPS along with §1395ww(b)(3)(A) and mandated this adjustment. Each petitioner's request was premised on the notion that the PPS-Medicare policy change for "exhausted coverage" days and the resulting exclusion of such operating costs from the base-year HSP calculation constituted an event beyond the hospital's control which produced a "distortion" between allowable costs in the base-period and the PPS transition years requiring an adjustment.

There was no factual dispute concerning the scope or the bona fides of the additional costs that would be subject to recognition under subsection (b)(4)(A). The intermediaries, however, denied the requests on the basis that the amounts in question were not considered "allowable operating cost[s] of inpatient services" during the base-year, and that an adjustment to eliminate this disparity was not among the "modifications" specifically delineated in

---

8. The exclusion of these costs reduced the "numerator" (i.e., total Medicare costs) referenced on p. 6 without affecting the denominator (i.e., total number of Medicare patients), thereby diluting the resulting target amount.

9. It is not necessarily the case that this particular disparity — which tends to occur for certain types of lengthy admissions, such as burn cases — occurs for all hospitals.

"current regulations," *i.e.*, "Section 405.474(b) [*redesignated* 412.71(b)]," a position confirmed by HHS.[10]

Petitioners filed "group appeals" before the Provider Reimbursement Review Board ("PRRB") for all transition years. (App. 28a, 31a, 34a) Pursuant to 42 U.S.C. 1395oo(f)(1), these were certified for "expedited judicial review" to the District Court because there were no disputed issues of fact, the PRRB is bound by Medicare regulations, and the pertinent regulations did not authorize the PRRB to grant the requested adjustments. (App. 28a, 31a, 34a) On review, the District Court awarded summary judgment to the Secretary, and the Court of Appeals for the District of Columbia Circuit affirmed.

The Court of Appeals held that the TEFRA provision requiring adjustments to the base-year where "events beyond a hospital's control" or "extraordinary circumstances" create a distortion in the increase in costs for a cost reporting period, 42 U.S.C. §1395ww(b)(4)(A), was only applicable to adjusting a hospital's target amount for TEFRA purposes and had not been incorporated into PPS. This determination was grounded in the Court's view that Congress did not incorporate the mandatory base-year adjustment provisions (for eliminating distortions beyond the hospital's control) of subsection (b)(4)(A) because the PPS provision, subsection (d)(1)(A), explicitly mentions only subsection (b)(3)(A). As a result, the Court held that the Secretary was not required to make the requested adjustments, and that the decision not to provide for adjustments to eliminate distortions between pre and post base-year operating costs was discretionary and enti-

---

10. In implementing PPS, the Secretary adopted regulations which gave to fiscal intermediaries responsible for setting the HSP extremely broad authority to "exclude" base-year costs which might improperly inflate the hospital-specific portion under PPS. 42 C.F.R. §§412.71 (b)(5), (6), (7) *formerly* 42 C.F.R. §405.474(b)(2)). In contrast, however, the Secretary more narrowly and presumptively limited the fiscal intermediaries' authority to increase base-year cost estimates in setting the HSP. Aside from being told to correct for ministerial and mathematical errors, 42 C.F.R. §412.72(a), intermediaries were instructed in formulating the HSP to use the best data available at the time in estimating each hospital's base-year costs and to allow modifications only to account for limited adjustments extending to the two specific examples of cost mismatches (FICA taxes, and certain costs reimbursed under Part B, which were not reimbursed under Part A in the base-year). 42 C.F.R. §412.71 (c)(1)(ii); §412.71(d) (*formerly* 42 C.F.R. §405.474(b)(2)(ii) and (iii)).

tled to deference.[11] Without addressing the Conference Report, or the prevailing contrary judicial authority, the Court concluded that adjustments to hospital-specific costs under PPS were limited to circumstances covered by discretionary adjustments recognized by the Secretary under regulations adopted pursuant to 42 U.S.C. §1395ww(d)(5)(I).

---

11. The District Court assumed that 42 U.S.C. §1395ww(b)(4)(A) required the Secretary to adjust base-year costs under PPS "where events beyond the hospital's control" produce a "distortion" between allowable cost in the base-period and the PPS transition years, but concluded that a coverage change effected by the Secretary was not within the ambit of events contemplated by the statute. Having dispositively ruled as a threshold matter that subsection (b)(4)(A) was not incorporated into PPS, the Court of Appeals did not address this issue. There is however little doubt that adjustments based on regulatory changes which expand Medicare coverage after the relevant base-year fall precisely within the class of extraordinary circumstances to which §1395ww(b)(4)(A) was addressed. Thus, under the Medicare Catastrophic Coverage Act of 1988 ("MCCA"), Pub. L. No. 100-360, 102 Stat. 683 (1988) (which was repealed after a brief period), Congress expanded Medicare coverage by eliminating the annual spell of illness and life time reserve days referenced above, and substituted unlimited days of coverage. In light of the expansion of Medicare coverage and the corresponding reduction in direct beneficiary and Medigap payments to hospitals, Congress instructed the Secretary expressly to adjust the TEFRA hospital-specific target rates to take into account any reduction in Medicare Part A payments to hospitals resulting from the elimination of the day limitation on Medicare coverage of inpatient hospital services. H.R. Rep. No. 100-105(I), 100th Cong., 2d Sess., *reprinted in* 1988 U.S.C.C.A.N. 803, 814. In adopting regulations under MCCA, the Secretary recognized the need under TEFRA to make "the *adjustment* . . . *available* to *any* hospital that *experiences a distortion* due to increased costs caused by the elimination of the inpatient entitlement limitation . . . . This is because any distortion will be due to the effect of . . . [*the change in law*] and essentially is unrelated to the actions of any individual hospital." 53 Fed. Reg. at 38520-21 (Sept. 30, 1988) (emphasis added). More recently, in *Harmarville Rehabilitation Center, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania*, PRRB Hearing Dec. No. 93-D42 (5/20/93), Case No. 85-1135, *reprinted in* Medicare & Medicaid Guide (CCH) ¶41,558, the PRRB held that an insurer's elective change in Medigap supplemental payment policies, which shifted the portion of inpatient costs paid previously by Medigap supplemental policies to the Medicare program, caused a significant distortion in the provider's Medicare inpatient operating costs for the base period and/or the first rate year which was beyond the provider's control and mandated a TEFRA adjustment under subsection (b)(4)(A). In so holding, the PRRB relied on the MCCA as clearly evidencing Congress' intention that post-base-year Medicare coverage expansions attributable to coverage changes imposed upon hospitals by third-party insurers (including direct coverage changes under Medicare or indirect Medicare coverage expansions resulting from reductions in discretionary cover-

REASONS FOR GRANTING THE PETITION

I. THE DECISION BELOW CREATES A CONFLICT AMONG THE CIRCUITS ON AN IMPORTANT QUESTION OF LAW

This case raises the important question of whether the TEFRA target amount adjustment provisions contained in 42 U.S.C. §1395ww(b)(4)(A) were incorporated into PPS, concerning which there is a clear cut split among the circuits. This issue potentially impacts all hospitals which experienced and were able to document significant changes in otherwise allowable operating costs occurring after their base-years but prior to the start date of PPS.[12] Among other things, this issue is controlling of whether the HSP is subject to adjustment in the case of hospitals that completed significant construction and experienced related changes in services after the base-year (factually, the scenario involved in the *Sacred Heart*, *Chandler* and *Methodist* cases *infra*). The failure to recognize adjustments designed to eliminate such distortions and attain comparability between the pre and post base-year operating costs of hospitals undermines the use of the HSP as a valid proxy of a given hospital's true costs throughout the extended transition period, and vitiates the buffer which Congress sought to impose against the "disruptions" and "severe financial dislocations" by tying a significant portion of hospitals' DRG payment rates on individualized, hospital-specific costs.

In two separate cases, *Community Hospital of Chandler, Inc. v. Sullivan*, 963 F.2d 1206 (9th Cir. 1992), and *Sunshine Health Systems v. Bowen*, 809 F.2d 1390 (9th Cir. 1987), the Ninth Circuit held that Congress clearly intended to incorporate §1395ww(b)(4)(A) into PPS. Numerous district courts which have addressed the issue have uniformly concluded that Congress intended subparagraph (b)(4)(A) to be incorporated into

---

age by "gap" insurers) are events requiring adjustments under §1395ww(b)(4)(A). Any doubt about this point is removed by the Secretary's proposed rule "clarifying" the TEFRA ceiling adjustment regulations specifically to reach such coverage changes. 57 Fed. Reg. 23660 (June 4, 1992). Accord 57 Fed. Reg. 39746, 39803 (Sept. 1, 1992 final rule).

12. Last term, in *Good Samaritan Hospital v. Shalala*, ___ U.S. ___, 113 S.Ct. 2151 (1993), this Court explored the reach and operation of a distinct but complementary set of Medicare cost limit rules that applied to pending cases still subject to the former reasonable cost reimbursement system.

(b)(3)(A) for PPS purposes.[13] By contrast, the Third Circuit in *Sacred Heart Medical Center v. Sullivan*, 958 F.2d 537 (3d Cir. 1992), *reversing* 1991 U.S. Dist. LEXIS 9535 (E.D. Pa. 1991), like the court below, acquiesced in the Secretary's (current) approach that target amounts are not subject to adjustments pursuant to §1395ww(b)(4)(A) for purposes of PPS.

Five separate cases turning on this issue are currently pending in the District Court for the District of Columbia.[14] Another such pending case, *Hillsborough County Hospital Authority, et al., v. Shalala*, 91-12-CIV-T-21 (M.D. Fla.) involves adjustment claims of 114 individual hospitals. Similarly, in *The Methodist Hospital, et al., v. Shalala*, Nos. 91-5405 and 92-5034 (D.C. Cir. 1993), the Court of Appeals for the District of Columbia Circuit recently removed from the argument calendar a series of consolidated cases that turn on whether the TEFRA adjustment provision was incorporated by PPS, apparently because the panel's decision below is controlling of all such cases.[15] The number of cases which have been brought by hospitals seeking similar adjustments to their HSP rates further underscores the need for a unified resolu-

13. The Ninth Circuit in *Chandler* noted with approval that numerous District Courts that have addressed this issue have similarly concluded that Congress intended subparagraph (b)(4)(A) to be incorporated into subparagraph (b)(3)(A) for PPS purposes. *See, The Methodist Hospital, et al. v. Sullivan*, C.A. No. 90-1871-GAG (D.D.C. September 20, 1991), Medicare & Medicaid Guide (CCH) ¶39,627, *appeal pending*, D.C. Cir. Nos. 91-5404 and 92-5034; *Newport Hospital and Clinic, Inc. v. Sullivan*, C.A. No. 88-2490-LFO (D.D.C. September 24, 1990) Medicare & Medicaid Guide (CCH) ¶38,844, *Secretary's appeal voluntarily withdrawn* (1991); *see also Greenville Hospital System v. Bowen*, No. 6:85-337-3 (D.S.C. 1986), Medicare & Medicaid Guide (CCH) ¶35,880, *vacated as a condition of settlement, Id.* ¶36,072 (D.S.C. 1986); *Redbud Hospital District v. Heckler*, No. C-84-4382-MHD (N.D. Cal. 1984), Medicare & Medicaid Guide (CCH) ¶34,085, *vacated on other grounds*, 473 U.S. 1308. Prior to the opinion below, the sole contrary decision was issued by the Third Circuit in *Sacred Heart Medical Center v. Sullivan*, 958 F.2d 537 (3d Cir. 1992), *reversing* 1991 U.S. Dist. LEXIS 9535 (E.D. Pa. 1991). This body of law was not even alluded to by the Court below, which recently denied a request for initial hearing en banc in *The Methodist Hospital* case.

14. *Nyack Hospital v. Sullivan*, No. 92-0455; *Okeechobee Hospital v. Sullivan*, No. 92-1323; *HCA Services of Texas v. Sullivan*, No. 92-1324; *Hospital Corporation of Tennessee v. Sullivan*, No. 92-1325; *General Care Corp. v. Sullivan*, No. 92-1326.

15. Petitioners are not able to ascertain precisely how many additional cases turning on this issue are pending before the PRRB.

tion to the question of whether the TEFRA adjustments were incorporated into PPS.

II. THE DECISION BELOW IS MANIFESTLY INCORRECT: CONGRESS PLAINLY REQUIRED THE SECRETARY TO APPLY THE TEFRA ADJUSTMENTS IN DETERMINING THE HOSPITAL-SPECIFIC PORTION OF MEDICARE REIMBURSEMENT

Congress clearly intended the TEFRA adjustments — which are an integral part of setting the TEFRA target amount — to be incorporated into PPS. "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984). Moreover, "[t]he judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear Congressional intent." *Id.* at 843 n.9. The lower court's determination that the PPS statute did not incorporate the TEFRA adjustments is based on an incomplete and superficial reading of the Act.

42 U.S.C. §1395ww(d)(1)(A) provides that during the PPS transition period, the payment for inpatient hospital services is determined by blending the federal DRG and the hospital's TEFRA "target amount . . . as defined in subsection [1395ww](b)(3)(A)." Target amounts under subsection (b)(3)(A) are, in turn, expressly and integrally subject to exceptions and adjustments provided under §1395ww(b)(4)(A), which states that:

> The Secretary shall provide for an exemption from, or an exception and adjustment to, the method *under this subsection* [1395ww(b)] for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the cost of the base period against which such increase is measured). (Emphasis added.)

Importantly, this disputed subparagraph refers to the method for determining the target amount "under this subsection", *i.e.*, §1395ww(b), which includes subparagraph (b)(3)(A). The PPS

provisions (§1395ww(d)(1)(A)) cross-reference and incorporate by express reference the TEFRA target amount determined under §1395ww(b)(3)(A), which is extricably linked under the TEFRA provisions to subsection (b)(4)(A).[16]

This interpretation was expressly upheld by the Ninth Circuit, which concluded that the reference to §1395ww(b)(3)(A) in §1395ww(d)(1)(A) was clearly intended by Congress to incorporate §1395ww(b)(4)(A). In *Chandler*, *supra*, the Court held that the Secretary was required to take into account additional costs incurred as a result of the construction of a new facility after the base year, but prior to the onset of PPS, stating:

> [W]e find that *Congress did intend to incorporate §1395ww(b)(4)(A)* [into §1395ww(d)]. As we have noted before, "although the PPS is basically embodied within 42 U.S.C. §1395ww(d) . . . there is clear interface between 1395ww subsections (b) and (d)." *Sunshine Health*, 809 F.2d at 1398 . . . . Thus, in light of the fact that §1395ww(d) "by its own terms incorporates one of the main concepts of subsection (b)," we found it illogical to exclude from PPS other subsections of §1395ww(b). *Id.*

Chandler, 963 F.2d at 1214 n.4 (emphasis added).[17]

Incorporation of the TEFRA adjustment into PPS is also compelled by negative inference, as other courts have recognized, *see Methodist*, *id.* (Gesell, D.J.). Thus, §1395ww(d)(1)(A) states that the PPS target amount is to be determined under §1395ww(b)(3)(A) but "without the application of subsection (a) of this section [§1395ww(a)] . . . ." If, as the lower court incorrectly held, the incorporation of the TEFRA target provisions were strictly limited to subsection (b)(3)(A) itself, so as to facially

---

16. As Judge Oberdorfer stated in rejecting the Secretary's contention that Congress did not mean to incorporate subparagraph (b)(4)(A) in *Newport*, *supra*:

> This contention has no merit. Subsection (b)(3)(A) defines "target amount" as the allowable costs as set forth in yet another subsection. Subsection (b)(4)(A) establishes exceptions to subsection (b), including (b)(3)(A). For this reason, subsection (b)(3)(A) cannot be cleanly extracted from its statutory environment even if Congress neglected to refer to (b)(4)(A) explicitly [in section (d)(1)(A)].

Medicare & Medicaid Guide (CCH) ¶38,844 at 24,063. *Accord Methodist*, *supra*, Medicare & Medicaid Guide (CCH) ¶39,627 at 28,117.

17. The Ninth Circuit expressly disagreed with the contrary view adopted by the Third Circuit. *Id.*

exclude consideration of (b)(4)(A), there would have been absolutely no reason for Congress to prescribe, in §1395ww(d)(1)(A), the incorporation of the TEFRA target amount determined pursuant to (b)(3)(A) "without the application of subsection (a) of this section [§1395ww]." Rather, it is clear that Congress intended to incorporate fully the target rate-setting mechanism of TEFRA, including the critically important, mandatory provisions of subsection (b)(4)(A) for neutralizing distorting differences in allowable base-year and post base-year costs, with the limited exception of the percentage limitations separately provided for under subsection (a). This was the only limitation imposed.

The act of expressly excluding one subsection raises an inference that the other subsections are not to be excluded. "[W]here Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied in the absence of evidence of a contrary legislative intent." *Andrus v. Glover Construction Co.*, 446 U.S. 608, 616, 617 (1980). Absent an express exclusion, the requirements of §1395ww(b)(4)(A) must be applied in determining the PPS target amount as defined in §1395ww(b)(3)(A) and §1395ww(d)(1)(A). If Congress had truly intended for the PPS target amount and resulting hospital-specific portion to be calculated also "without application of subparagraph (b)(4)(A)" — the TEFRA adjustment — it would have said so. Like the Third Circuit in *Sacred Heart*, the court below simply glossed over this central principle of statutory construction. Indeed, the Court below did not even mention the fact that §1395ww(d)(1)(A) specifically excluded §1395ww(a) in deferring to the Secretary's current interpretation.

Congress' clear expectation that the Secretary take steps necessary to eliminate any identifiable and quantifiable "mismatches" between pre and post allowable costs in setting the HSP is also underscored by the Conference Report attending the PPS amendment, which states:

> The managers note that during the phase-in period, some portion of the prospective payment rate will be related to each hospital's own experience in a base-cost reporting year. *The managers recognize that, in some cases, the Secretary will have to use estimates to adjust some portions of the hospital's base-year experience to make it comparable to inpatient operating costs that will be paid under the prospective system — e.g.*, FICA

> taxes that would have been paid if the hospital had been in the social security system or the adjustment needed to exclude the nursing differential which is no longer payable. *Since the hospital specific portion of the rate must be determined in advance of the hospital's first fiscal year under the system, the managers expect the Secretary will use the best data available at the time to determine operating costs* for purposes of the phase-in. (Emphasis added.)

H.R. Conf. Rep. No. 98-47, 98th Cong. 1st Sess. 182, *reprinted in* 1983 U.S.C.C.A.N 404, 471-72. Similarly, the Senate Committee recognized that various "exceptions and adjustments" were appropriate to take such situations into account in that "the prospective payment is intended to be *payment in full for all covered items and non-physician services to hospital inpatients* (emphasis added)." S. Rep. 98-23 at 49, 50, U.S.C.C.A.N. at 189, 190. This legislative history is consistent with, and, indeed, unmistakenly confirms Congress' expectation that the TEFRA base-year cost adjustments were to be made by the Secretary in setting the HSP.[18] These reports were ignored by the Court below.

The lower court erroneously concluded that incorporating subsection (b)(4)(A) would have been redundant because of the fact that one PPS provision, 42 U.S.C. §1395ww(d)(5), separately and independently affords the Secretary discretion to recognize exceptions and adjustments under PPS. (App. 7a) To the contrary, 42 U.S.C. §1395ww(d)(5)(A)-(H) authorizes certain specific adjustments and exceptions for certain classes of hospitals and cases throughout the course of PPS (e.g., special rules for extraordinarily lengthy hospital stays; reimbursement of sole community

18. In recent cases involving this issue, the Secretary has disingenuously cited in isolation a statement in a Committee Report that a hospital's target amount under PPS would be adopted "without regard to the exemptions, exceptions and adjustments which may have been authorized under TEFRA for that year." H.R. Rep. No. 98-25, 98th Cong., 1st Sess. 132, 136, *reprinted in* 1983 U.S.C.C.A.N. at 355. This quotation is totally misleading. It refers to a version of the bill H.R. 1900, Rep. No. 98-25, Part I, 98th Cong. 1st Sess. that was never enacted. The reference therein was to a distinct set of exceptions to rates determined using TEFRA percentage limits (found in §1395ww(a)(2)) which were *not* included in the target amount setting formulation ultimately adopted by the Conference Committee. The reference to these particular exemptions, exceptions and adjustments thus became moot. As to the final version actually enacted by Congress, the statement in the Conference Report expressly recognizes the need to make "adjustments" to the target amount ultimately selected for setting the HSP.

hospitals). 42 U.S.C. §1395ww(d)(5)(I) gives the Secretary general discretionary authority to provide for other exceptions and adjustments "as the Secretary deems appropriate." Subsection (b)(4)(A), on the other hand, distinctly deals only with setting *hospital-specific target amounts* for the transition period. Adjustments to the target amount were *mandated* where the conditions delineated in that subsection, i.e., certain types of events or circumstances which distort the comparability of base-year operating costs, are met. Subsection (d)(5)(I) is a far broader "catch-all," providing for all manner of discretionary exceptions which the Secretary might decide to adopt in applying DRG payments to PPS hospitals. These provisions are thus readily reconciled.

Finally, the lower court noted (App. 6a) that:

> [S]ubsection (b)(4)(A) explicitly authorizes the Secretary to depart from the 'target amount' benchmark in (b)(3)(A) in specific circumstances, suggesting that incorporation of (b)(4)(A) might conflict with the congressional intent partially to base reimbursement on the target amount during the PPS transition period.

This point is a red herring. The only provision of subsection (b)(A)(4) to which the Court could be referring (since none is identified) concerns the assignment of a new base period which is more representative of the reasonable and necessary costs that a hospital incurs after its base year for TEFRA cost limit purposes.[19] What the Court apparently did not recognize is that subsection (b)(4)(A) was amended to permit the assignment of a new base year for PPS-exempt hospitals by the Omnibus Budget Reconciliation Act of 1989, §§6015(a) and (b), well after the expiration of the transition period relevant to this appeal. Thus, the provision which apparently caused the Court concern is totally irrelevant to analysis of subsection (d)(1)(A).

---

19. *See* n. 4, *supra*.

III. THE DECISION BELOW MISAPPLIES CHEVRON AND ITS PROGENY AND ENDORSES A STANDARD OF REVIEW THAT FRUSTRATES CONGRESSIONAL INTENT

The lower court has construed the standards for statutory construction in a manner which gives regulatory agencies wide rein to frustrate clearly expressed congressional intent. The decision below not only ignores what most courts have found to be an obvious legislative mandate, it affords controlling significance to an agency litigation position that is plainly at odds with the Secretary's contemporaneous construction of the Act and represents a clear flip-flop from the view enunciated contemporaneously when the statutory machinery was being put into motion. *See Udall v. Tallman*, 380 U.S. 1, 16 (1985).

A. This Court's decision in *Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), provides the proper framework in which to review an agency's construction of a statute:

> First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the Court, as well as the agency, must give effect to the unambiguously expressed intent of Congress . . . . [However,] if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Id. 467 U.S. at 842-43. "The traditional deference courts pay to agency interpretation is not to be applied to alter the clearly expressed intent of Congress." *Board of Governors of the Federal Reserve System v. Dimension Financial Corp.*, 474 U.S. 361, 368 (1986). A reviewing court must reject the Secretary's statutory construction if it is "inconsistent with the statutory mandate or . . . frustrate[s] the policy that Congress sought to implement." *Securities Industry Ass'n v. Board of Governors of the Federal Reserve System*, 468 U.S. 137, 143 (1984), *citing FEC v. Democratic Senatorial Campaign Committee*, 454 U.S. 27, 32 (1981).

In ascertaining the plain meaning of a statute, the judicial inquiry must encompass both the particular statutory language and the broader design of the statute. *K Mart Corp. v. Cartier, Inc.*, 486 U.S. 281, 291 (1988). Moreover, in determining whether

the Secretary's approach is consistent with that of Congress, a reviewing court must look to both the statute and the legislative history. *Chevron* at 842-43; *Georgetown* at 326, 328; *Washington Hospital Center* at 143, 148-49; *New York City Health and Hospitals Corp. v. Parales*, 954 F.2d 854, 858 (2d Cir.), *cert. denied*, ___ U.S. ___, 113 S.Ct. 461 (1992). The court below inexplicably ignored the pivotal pronouncement of the Conference Committee (pp. 14-15, *supra*; emphasis added) that the Secretary "*will have to*" affect adjustments fitting the precise description of the TEFRA adjustment provisions, i.e., to "make it [the hospital's base-year experience] *comparable to inpatient operating costs that will be paid under PPS*" in setting the hospital-specific rate under PPS. In failing to even consider the legislative history of the PPS statute, the Circuit Court violated a fundamental precept of the *Chevron* doctrine.

Congress spoke "directly to the precise question at issue in the instant case." As shown above, the requirement to eliminate distorting mismatches in pre and post-base year allowable costs attributable to coverage changes beyond the providers' control is explicit under the statute, and directly reinforced in the legislative history. Congress clearly intended to slowly wean hospitals from the cost reimbursement system by only gradually divorcing their payments from a hospital-specific cost approach. Of necessity, the HSP component incorporated into the prospectively applied transition period rate had to be fixed in advance. But Congress intended the target amount to represent as close a proxy as reasonably possible to actual allowable hospital-specific costs that would be incurred during the transition period. Failing to adjust a hospital's base-year costs in accordance with Section 1395ww(b)(4)(A) collides with the plain design of the Medicare Act, and frustrates Congress' plainly expressed intent to eliminate significant distortions between base-year costs and PPS rate-year costs during the limited duration of the transition period.

B. Every district court, and every court to consider the issue until *Sacred Heart Medical Center v. Sullivan*, has held that the statute, taken in the context, clearly indicates Congress' intent to incorporate the TEFRA adjustments into PPS. None of these courts even reached the second step of a *Chevron* inquiry, *i.e.*, the reasonableness of the agency's interpretation. Assuming *arguendo* that a court could find that the congressional intent was

not manifest, the Secretary's current interpretation of subsection (d)(1)(A) would be due no deference because it (1) represents a totally unexplicated about-face from the Secretary's contemporaneous interpretation and application of subsection (d)(1)(A), and (2) is a litigation position which constitutes nothing more than a *post-hoc* rationalization.

Deference to the Secretary in these circumstances is flatly contrary to this Court's instruction that no deference is due to an agency position which amounts to an unexplicated reversal of field or the *post-hoc* rationalization of counsel. *Motor Vehicle Manufacturers Ass'n v. State Farm Auto Ins. Co.*, 463 U.S. 29, 43 (1983). *See also Bowen v. Georgetown University Hospital*, 488 U.S. 204, 212-13 (1988); *Securities Industry Ass'n*, 468 U.S. at 143-44. Deference in these circumstances is also counter to this Court's reasoning concerning varying agency interpretation of law in *Good Samaritan Hospital v. Shalala*, ___ U.S. ___, 113 S.Ct. 2151 (1993), the import of which should be further clarified on review of the instant case.

Although this was not even alluded to in the lower court's analysis of subsection (d)(1)(A), the preamble to the Secretary's final regulations implementing PPS states unequivocally that:

> We believe that Congress intended to assure, by giving us broad authority under the law to provide for exceptions, exclusions and adjustments, that some hospitals are not advantaged or disadvantaged by unique circumstances in their base year that do not reflect their usual cost of operation per case. *This intent is indicated in Section 1886(b)(4)(A) of the Act* (emphasis added).

49 Fed. Reg. at 261 (Jan. 3, 1984). Thus, at the outset of PPS, the *Secretary* pronounced that the TEFRA adjustment provisions of subsection (b)(4)(A) applied in calculations of the hospital-specific portion of the PPS rate.[20]

In the *Greenville, supra*, litigation, which took place within a year of that publication, the Secretary agreed to make adjustments to the HSP based on the standards of subsection (b)(4)(A)

20. This conclusion was later reiterated in a notice of proposed rulemaking published in 1986. 51 Fed. Reg. 8208, 8210 (Mar. 10, 1986). That proposed rule contained a "clarification" of policy which indicated that §1395ww(b)(4)(A) provided authority for adjusting the HSP by proposing to expressly incorporate the TEFRA regulations (42 C.F.R. §405.463 (1985), subsequently redesignated 42 C.F.R. §413.40) into PPS. The proposed rule, however, purported to permit

for purposes not specifically listed in 42 C.F.R. §§412.71 and 412.72. When the instant case was originally brought before the District Court, the Secretary, although making token statements to the contrary, assumed *arguendo* that the TEFRA standard applied under PPS, specifically directing that court's attention to the decision in *Sunshine Health Systems v. Bowen*.[21] Indeed (and apparently unbeknownst to the Third Circuit), HHS *continued* to cite and apply the standards of subsection (b)(4)(A) in actual practice, granting "distortion"-eliminating adjustments after publication of the proposed rule in 1986. In a policy letter (which was evaluated in *Newport Hospital and Clinic v. Sullivan, supra*), Linda Magno, Director of the Health Care Financing Administration's Division of Hospital Payment Policy, expressly acknowledged the application of the TEFRA exception and adjustment clause to PPS.

The Secretary's position advanced before the appeals court in the instant case is thus inconsistent *inter alia* with the agency's position in *Chandler*, HHS's actions in the *Greenville* and *Newport* litigation, and with the official policy statement published when the PPS system was being implemented. As this Court recently held:

> the consistency of an agency's position is a factor in assessing the weight that position is due. As we have stated, "[a]n agency's interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held view." *INS v. Cardoza-Fonesca*, 480 U.S. 421, 466 n. 30 (1987) (*quoting Watt v. Alaska*, 451 U.S. 259, 273 (1981)). How much weight should be given to the agency's views in such a situation.... will depend on the facts of individual cases. [*Id.* (citation omitted).]

---

only prospective adjustment of the HSP only for those years still remaining under transition period after the adjustment was approved; the rule was never adopted in final form, ostensibly because the D.C. Circuit thereafter held in *Georgetown* that challenges to base-year costs included in the HSP, if timely appealed, had to be made retroactive to the outset of the PPS transition period. Ironically, the Third Circuit in *Sacred Heart* misconstrued this unpublished proposal as a more recent agency interpretation of the statute disavowing the incorporation of subsection (b)(4)(A) adjustments under PPS.

21. In fact, in *Chandler*, counsel for the Secretary appears to have acknowledged that TEFRA adjustments are available under PPS but that regulations clarifying the procedures for requesting such adjustments have not been promulgated. 963 F.2d at 1214 n. 4.

Good Samaritan Hospital v. Shalala, 113 S.Ct. at 2161. The Secretary has not changed her position on the incorporation of the TEFRA provisions into PPS as a result of divergent or erroneous court decisions. Rather, she has reversed her position arbitrarily and for no apparent reason except to prevent having to pay hospitals additional sums of money.[22]

Absent a definitive ruling from this Court, the Secretary will be free to change her opinion on this issue depending upon the court in which HHS is proceeding. Such an ad-hoc approach has and will continue to result in certain hospitals being granted adjustments to their base year figures under 42 U.S.C. §1395ww(b)(4)(A) while others are denied the very same adjustments. Under a system designed to compensate Medicare providers on a uniform basis, such variations in reimbursement are unacceptable. This case presents an appropriate vehicle for refining the circumstances when agency vacillations deny deference to the agency's interpretations.

---

22. Although the Court of Appeals made conclusory statements to the contrary, there was absolutely *no* rational justification officially advanced by HHS, in regulations or otherwise, for her about-face here, and no explanation given for allowing fiscal intermediaries open discretion to effect only negative adjustments to base-year costs.

CONCLUSION

For the foregoing reasons, this Court should grant the petition and issue a writ of certiorari to the United States Court of Appeals for the District of Columbia Circuit.

Date: Philadelphia, Pennsylvania
September 16, 1993

Respectfully submitted,

WOLF, BLOCK, SCHORR and SOLIS-COHEN

/s/ MARK H. GALLANT

Mark H. Gallant
Counsel of Record

Ellen N. Berman

WOLF, BLOCK, SCHORR and SOLIS-COHEN
12th Floor, Packard Building
S.E. Corner 15th & Chestnut Streets
Philadelphia, PA 19102-2678
(215) 977-2000
Attorneys for Petitioners

93-429

No.

Supreme Court, U.S.
FILED
SEP 16 1993
OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

EPISCOPAL HOSPITAL, ET AL.,

Petitioners,

v.

DONNA E. SHALALA, SECRETARY, HEALTH AND HUMAN SERVICES,

Respondent.

APPENDIX TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

MARK H. GALLANT
Counsel of Record

ELLEN N. BERMAN

WOLF, BLOCK, SCHORR AND SOLIS-COHEN
Twelfth Floor Packard Building
S.E. Corner 15th & Chestnut Sts.
Philadelphia, PA 19102-2678
(215) 977-2000
Attorneys for Petitioners

TABLE OF CONTENTS

	Page
Appendix A (Court of Appeals' Opinion dated June 18, 1993)	1a
Appendix B (Court of Appeals' Judgment dated June 18, 1993)	10a
Appendix C (District Court's Memorandum Opinion dated November 12, 1991)	11a
Appendix D (District Court's Order and Judgment dated November 12, 1991)	24a
Appendix E (District Court's Stipulated Order and Judgment dated December 18, 1991)	25a
Appendix F (Provider Reimbursement Review Board's Determination dated May 8, 1990)	28a
Appendix G (Provider Reimbursement Review Board's Determination dated May 6, 1991)	31a
Appendix H (Provider Reimbursement Review Board's Determination dated April 12, 1989)	34a
Appendix I (Relevant Statutory Provisions)	36a
Appendix J (Relevant Regulations)	44a

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Nos. 92-5033, 92-5034

EPISCOPAL HOSPITAL, ET AL., APPELLANTS,

v.

DONNA E. SHALALA, SECRETARY, HEALTH AND HUMAN SERVICES, APPELLEES.

Argued March 18, 1993
Decided June 18, 1993

OPINION

Before: EDWARDS, SENTELLE and HENDERSON, Circuit Judges.

SENTELLE, Circuit Judge.

This is an appeal from a District Court judgment upholding the validity of regulations issued by the Secretary of Health and Human Services (the "Secretary") under 42 U.S.C. § 1395ww(d) (1988), which sets forth the methodology for calculating hospitals' Medicare cost reimbursement under the Prospective Payment System ("PPS"). Appellants argue that the Secretary's PPS regulations are based in part on an erroneous interpretation of the enabling statute, or are arbitrary and capricious. The District Court disagreed; we reach the same result and therefore affirm the District Court's judgment.

I. BACKGROUND

A. *Statutory and Regulatory Framework*

Part A of the Medicare Program, 42 U.S.C. § 1395c *et seq.* (1988 & 1991 Supp. III), authorizes payment for primary institutional care, such as hospital services, to eligible aged and disabled

persons. Providers of these services are reimbursed by fiscal intermediaries designated by the provider and the Secretary. 42 U.S.C. § 1395h (1988); 42 C.F.R. § 421.103 (1992). Under Part A, Medicare beneficiaries receive coverage for 90 days of hospital inpatient services in each benefit period, as defined by the statute and regulations, plus an additional 60-day lifetime reserve. 42 U.S.C. § 1395d (1991 Supp. III); 42 U.S.C. § 1395q (1988); 42 C.F.R. § 409.60 *et seq.* (1992).

Until October of 1983, the Medicare Program reimbursed hospitals and other health care providers for the "reasonable cost" of covered services, defined as the "cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v) (1988). Under this reasonable-cost regime, hospitals providing inpatient care to Medicare patients received reimbursement for allowable operating costs of services provided to patients, but only to the extent the services were provided on days for which the patients had Medicare coverage. *Id.* § 1395q(d).

Concerned that hospitals had little incentive to reduce or contain costs because reasonable cost reimbursement shifts the burden of cost increases from hospitals to the federal government, Congress enacted provisions in the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), Pub. L. No. 97-248, 96 Stat. 324 (1982) (codified at scattered sections of 42 U.S.C.), to address containment of Medicare costs. While the TEFRA provisions left the basic retrospective, cost-based structure of Part A reimbursement undisturbed, it imposed a limit on the rate of increase of Part A reimbursement.

Under TEFRA, the rate-of-increase limit for each hospital was tied to a "target amount." This amount was the hospital's allowable costs of inpatient hospital services for the preceding cost reporting period, increased by a specified percentage in each succeeding cost reporting period. 42 U.S.C. § 1395ww(b)(3)(A) (1988). Though hospitals were subject to reductions in the amount of their Part A reimbursements if their operating costs exceeded the applicable target amounts, *id.* § 1395ww(b)(1)(B), they received bonuses if their operating costs were less than their target amounts. *Id.* § 1395ww(b)(1)(A); 42 C.F.R. § 413.40 (1992).

TEFRA also set out specific exceptions and adjustments to the new limits. Section 1395ww(b)(4)(A) directed the Secretary to

"provide for an exemption from, or an exception and adjustment to, the [rate of increase] method . . . where events beyond the hospital's control or extraordinary circumstances . . . create a distortion in the increase in costs for a cost reporting period." 42 U.S.C. § 1395ww(b)(4)(A). In addition, the subsection authorized the Secretary to "provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate." *Id.; see also* 42 C.F.R. § 413.40(f)-(g) (exemptions and adjustments).

In 1983, Congress replaced the TEFRA-mandated system with a more radical reform of inpatient cost reimbursement, known as the Prospective Payment System. *See* Pub. L. No. 99-272, § 9102, 100 Stat. 155 (1986) (codified as amended, 42 U.S.C. § 1395ww(d) (1988 & 1991 Supp. III)); 42 C.F.R. § 412.1 *et seq.* (1992). Under this system, hospitals and other health care providers are reimbursed on the basis of prospectively determined national and regional rates, rather than reasonable operating costs. The system classifies Medicare patients into one of approximately 470 "diagnosis related groups" ("DRGs") based on differences in patients' utilization of hospital resources by groups and establishes fixed rates for each. The PPS rates do not vary according to the actual costs of individual cases, but are designed to allow efficient providers to recover their average costs of serving Medicare patients during a cost reporting period.

In enacting the PPS, Congress simultaneously provided for various exceptions and adjustments, as it had when it enacted TEFRA's rate-of-increase limit. Section 1395ww(d)(5) directs the Secretary to implement specific exceptions and adjustments, 42 U.S.C. § 1395ww(d)(5)(A)-(H), and to provide by regulation for other exceptions and adjustments to payment amounts "as the Secretary deems appropriate." *Id.* § 1395ww(d)(5)(I). In contrast to the analogous provision in TEFRA, however, § 1395ww(d)(5)(I) does not direct the Secretary to adjust reimbursement amounts where "extraordinary circumstances" distort the increase in costs for a particular cost reporting period.

Though eager to restrain health care costs, Congress recognized that immediate institution of the PPS could pose financial hardship for many health care providers. It therefore created a four-year transition period between the reasonable cost system and the PPS, 42 U.S.C. § 1395ww(d), designed to "minimize disruptions

that might otherwise occur because of a sudden change in reimbursement policy." H.R. REP. No. 25, 136, 98th Cong., 1st Sess., *reprinted in* 1983 U.S.C.C.A.N. 355.

During the transition period, the government was required to reimburse hospitals for inpatient hospital services according to a "blended" rate, based upon two components. The first was the hospital-specific portion ("HSP"), defined as a hospital's "allowable operating costs of inpatient hospital services" in a prior base year, *i.e.*, the Medicare cost year ending on or after September 30, 1982. 42 U.S.C. § 1395ww(b)(3)(A). The HSP is a percentage of the hospital's target amount as defined in subsection (b)(3)(A). The second element was the "federal" portion, a computation from regional and national DRG rates approaching the PPS rate. 42 U.S.C. § 1395ww(d)(2)(A), (B). Over the course of the four-year transition period, the portion of the reimbursement amount attributable to the prospective rate became progressively larger and HSP progressively smaller, until the prospective rate formed the exclusive basis for PPS reimbursement at the end of the transition period. *Id.* § 1395ww(d)(1)(C).

In implementing the PPS, the Secretary promulgated regulations modifying prior Medicare coverage rules. *See* 48 Fed. Reg. 39,752 (1984) (codifed at 42 C.F.R. § 405 *et seq.* (1992)). Inpatient hospital stays involving at least one day of Medicare eligibility would be treated as fully "covered" stays under Part A, for which the PPS payment itself would represent payment in full, regardless of the length of stay or extra costs attending the patient's recovery. 42 C.F.R. § 412.2(b)(2) (1992) (formerly 42 C.F.R. § 405.70(b)(2)(ii) (1984)). Because hospitals were prohibited from billing costs not fully reimbursed by Medicare, *id.* § 412.42(a), the "balance," in effect, was no longer reimbursable.

B. *Facts*

Appellants in this case are seven short-term acute care hospitals providing inpatient care under the Medicare program. Through their fiscal year ending June 30, 1984, appellants received reimbursement under the reasonable cost system. During the transition years, their PPS rates, including the HSP, were calculated by their intermediaries before the start of their first year under the PPS and were annually updated and used to determine their PPS payments per discharge. Excluded from the base-year costs were

costs associated with care furnished to Medicare beneficiaries for hospitalization after their Medicare coverage had been exhausted, costs for which Medicare had reimbursed the hospitals under the reasonable cost system. The hospitals sought an adjustment from their intermediaries to include these costs in the base-year totals, for purposes of calculating the HSP of their PPS rates. The intermediaries declined to adjust the costs because the Secretary's regulations did not provide for such an adjustment. The hospitals appealed to the Provider Reimbursement Review Board, which, on April 12, 1989, certified the issue for expedited judicial review pursuant to 42 U.S.C. § 1395oo(f) (1988).

The hospitals then filed the present action in the United States District Court on June 15, 1989, requesting an order compelling the Secretary to compensate them for costs that were improperly excluded from the hospital-specific portions of their transition-year payment rates. On cross-motions for summary judgment, the District Court reviewed the record and concluded that the Secretary had acted lawfully in not providing for adjustments to hospitals' base-year costs to reflect costs associated with care furnished to patients after their Medicare coverage had been exhausted. *Episcopal Hosp. v. Sullivan*, Medicare & Medicaid Guide, (CCH) ¶ 39,817 (D.D.C. 1991). The court assumed, without discussion, that 42 U.S.C. § 1395ww(b)(4)(A), which authorizes the Secretary to make adjustments in "extraordinary circumstances," applies to transition rates under PPS. However, the court upheld as based on a permissible reading of the statute the Secretary's conclusion that promulgation of a new regulation treating exhausted stays differently than under reasonable cost reimbursement was not an event "beyond the hospital's control or extraordinary circumstances" within the meaning of § 1395ww(b)(4)(A). The court also concluded that the Secretary did not abuse her discretion under § 1395ww(d)(5)(D) to provide the adjustment the hospitals sought.

This appeal followed.

II. Discussion

Appellants argue in the first instance that the plain meaning of the enabling statute required the Secretary to make adjustments they seek. In the alternative, they argue that even if the statute

does not require the Secretary to make the requested adjustments, the Secretary's refusal to make the base-year adjustments was arbitrary and capricious.

Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984), provides the proper framework for the statutory interpretation issue. That case held that

> First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. . . . [However,] if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Id. at 842-43.

Appellants rely on § 1395ww(b)(4)(A), which states that "[t]he Secretary shall provide for an exemption from, or an exemption and adjustment to, the [statutory rate of increase] method . . . where events beyond the hospital's control or extraordinary circumstances . . . create a distortion in the increase in costs for a cost reporting period." 42 U.S.C. § 1395ww(b)(4)(A). They note that § 1395ww(d)(1)(A)(i)(I) incorporates by reference the TEFRA "target rate" definition of subsection (b)(3), for purposes of setting the PPS base-period, hospital-specific costs. Subsection 1395ww(b)(3), they argue, is in turn subject to the provisions of subsection 1395ww(b)(4)(A), which requires the Secretary to make adjustments to the target rate in "extraordinary circumstances." *Id.* § 1395ww(b)(4)(A). Thus, appellants conclude that § 1395ww(d)(1) explicitly incorporates subsection (4)(A)'s extraordinary-circumstances mandate.

We do not agree. Section 1395ww(b)(3)(A), defining "target amount," plainly does *not* incorporate subsection (b)(4)(A). In fact, section 1395ww(b)(3)(A) never mentions that subsection, although it does refer to other exceptions from the target amount method determined under subparagraph (b)(3)(A). *See* 42 U.S.C. § 1395ww(b)(3)(A). Nor does subsection (b)(4)(A) either define "target amount" or modify the definition set forth in (b)(3)(A). In fact, subsection (b)(4)(A) explicitly authorizes the Secretary to depart from the "target amount" benchmark in (b)(3)(A) in specific circumstances, suggesting that incorporation of (b)(4)(A)

might conflict with the congressional intent partially to base reimbursement on the target amount during the PPS transition period. Certainly, the fact that Congress clearly incorporated subsection (b)(3)(A), while never referring to subsection (b)(4)(A), suggests that when Congress intended to incorporate a TEFRA provision into PPS, it did so expressly and that it did not intend to incorporate the provision at issue here.

Furthermore, appellants are unable to reconcile their argument with § 1395ww(d)(5). That section mandates specific adjustments and exceptions to the amount a hospital may be reimbursed for its inpatient operating costs under the PPS, *see* § 1395ww(d)(5)(A)-(H), and gives the Secretary general authority to provide for other exceptions and adjustments "as the Secretary deems appropriate." *Id.* § 1395ww(d)(5)(I). The quoted language also appears in subsection (b)(4)(A); significantly, however, subsection (d)(5) contrasts with subsection (b)(4)(A), insofar as the former does not include a provision for upward modification of a hospital's target rate in "extraordinary circumstances." *Compare* 42 U.S.C. § 1395ww(d)(5)(I) *with id.* § 1395ww(b)(4)(A).

In light of the foregoing, not only are we unable to agree with appellants that the statute requires the Secretary to make the requested adjustments, but it appears that the meaning may be quite the contrary. Even if we admit the possibility of other interpretations, appellants still do not prevail. Under the second step of *Chevron*, we "need not conclude that the agency construction was the only one it permissibly could have adopted to uphold the construction, or even the reading the court would have reached if the question initially had arisen in a judicial proceeding." *Chevron*, 467 U.S. at 843 n.11. We need only determine "whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843. In short, to the extent that the statute is ambiguous, the Secretary's interpretation, which is a permissible one for the reasons given above, must be upheld.

Having upheld the Secretary's reading of the statute under the *Chevron* analysis, we turn to appellants' second argument, that the Secretary's promulgation and application of the implementing regulations was arbitrary and capricious.

The appropriate standard for reviewing the Secretary's exercise of the discretion afforded under the statute is dictated by 42

U.S.C. § 1395oo(f)(1), which incorporates the Administrative Procedure Act ("APA"), 5 U.S.C. § 706(2)(A) (1988). Under the APA, we hold unlawful and set aside only those agency actions that we find "arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law." *Id.* Insofar as the question of whether the Secretary's regulations are in accordance with law, it follows from our analysis above the Secretary acted consistently with the statutory mandate, and in furtherance of the congressional goals.

As to the argued arbitrariness or capriciousness of the form she chose for doing so, we have often made it plain that we do not sit to interfere with the policy decisions of an agency, *Ethyl Corp. v. EPA*, 541 F.2d 1, 34 (D.C. Cir.) (en banc), *cert. denied*, 426 U.S. 941 (1976) (noting that this Court is "forbidden from substituting [our] judgment for that of the agency"), and we will not do so here. A review of the Secretary's official explanation of the final rules, 49 Fed. Reg. 234, 246-49 (1984), reveals that the Secretary responded to the comments that were in fact submitted. She revealed her goals and reasoning. She gave us a record which "will enable us to see what major issues of policy were ventilated by the . . . proceedings and why the agency reacted to them as it did." *Walter O. Boswell Mem. Hosp. v. Heckler*, 749 F.2d 788, 794 (D.C. Cir. 1984) (internal quotation marks omitted). She did, in short, all that the APA required.

We note that the root cause of appellants' objection to the PPS implementing regulations lies not in the refusal of adjustments, but rather in 42 C.F.R. § 412.42(a), which prohibits hospitals from charging Medicare patients whose bills exceed the amount paid to the hospital under the PPS. That regulation reads as follows:

> A hospital may not charge a beneficiary for any services for which payment is made by Medicare, even if the hospital's cost of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment systems.

Id. Obviously, this regulation may prevent health care providers from recouping losses which they may sustain when a Medicare patient remains with them beyond the average stay per ailment or requires greater than average care. There is, however, nothing we can do for appellants in this regard as they have not challenged § 412.42(a), but only the Secretary's discretionary refusal to

adjust the base-year computations to offset the effect of the change in regulations. *See Association of Accredited Cosmetology Schools v. Alexander*, 979 F.2d 859, 862 (D.C. Cir. 1992) (courts ordinarily do not address new legal theories on appeal).

III. Conclusion

For the reasons set forth above, we hold that the plain language of the PPS statute and its implementing regulations support the Secretary's contention that the PPS does not include an "emergency circumstances" provision. Further, the Secretary's implementation of the statute was neither arbitrary, capricious, nor unlawful. Therefore, the judgment of the District Court is hereby

Affirmed.

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Nos. 92-5033, 92-5034

EPISCOPAL HOSPITAL, ET AL., APPELLANTS,

v.

DONNA E. SHALALA, SECRETARY, HEALTH AND HUMAN SERVICES, APPELLEES.

Argued March 18, 1993
Decided June 18, 1993

JUDGMENT

Before: EDWARDS, SENTELLE and HENDERSON, Circuit Judges.

These causes came on to be heard on the record on appeal from the United States District Court for the District of Columbia and were argued by counsel. On consideration thereof, it is

ORDERED and **ADJUDGED,** by the Court, that the judgment of the District Court appealed from in these causes is hereby affirmed, in accordance with the Opinion for the Court filed herein this date.

Per Curiam
FOR THE COURT:
RON GARVIN, CLERK

BY: /s/ ROBERT A. BONNER

Robert A. Bonner
Deputy Clerk

Date: June 18, 1993

Opinion for the Court filed by Circuit Judge Sentelle.

APPENDIX C

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

CIVIL ACTION NO. 89-1716

EPISCOPAL HOSPITAL, ET AL., PLAINTIFFS,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT.

November 12, 1991

MEMORANDUM OPINION

JOHNSON, District Judge.

Plaintiffs are seven short-term acute care nonprofit hospitals which participate in the Medicare program. They challenge as arbitrary and capricious a refusal by the Secretary of Health and Human Services ("the Secretary") to adjust the hospital-specific portion of their payment rates during the transition period from the "reasonable cost" Medicare payment system to the current "prospective payment system" ("PPS"). Plaintiffs claim that they are entitled to an upward adjustment of these payment rates because of a change in the Secretary's regulation governing Medicare coverage of hospital stays consisting in part of non-payable Medicare days. Pending before the Court are the parties' cross-motions for summary judgment. There are no disputes of material fact. For the reasons outlined below, the Court will grant defendant's motion for summary judgment and deny plaintiffs' motion for summary judgment.

BACKGROUND

A. *General Statutory Background*

Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc (1988), commonly known as "Medicare," was created by

the Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 291. It is a nationwide health insurance program primarily for people who are aged sixty-five and over, and it is available to covered beneficiaries without regard to income or wealth.

Until 1983, the Medicare program paid for hospital care on a retrospective, "reasonable cost" basis. At the end of each fiscal year, a hospital provider would file with its "fiscal intermediary" a report indicating the total costs for which the provider sought Medicare reimbursement. The fiscal intermediary, who was bound by the Secretary's regulations and by Manual instructions issued by the Health Care Financing Administration (HCFA), would audit the report and issue a Notice of Program Reimbursement, indicating which of the provider's costs would be considered "allowable," and thus reimbursable, under Medicare.

Because the reasonable cost reimbursement system offered hospitals little incentive to keep their costs down, Congress set about to change Medicare's system of reimbursement. In April 1983, Congress enacted a new Medicare reimbursement scheme called the Prospective Payment System ("PPS"). Rather than reimbursing hospitals for the actual costs of providing services, PPS reimburses providers on the basis of a predetermined fixed rate for each discharge covered by Medicare; the fixed rate is a multiple of a flat payment rate and a weighting factor that is based upon the particular patient's "diagnosis-related group" ("DRG"). Each DRG weight represents the average resources required to care for cases in a particular DRG relative to the national average resources consumed per case by the average hospital. Thus, cases in a DRG with a weight of 2.0 would, on average, require twice as many resources as the average case for the average hospital. Generally, the hospital would receive this amount for the discharge, regardless of the individual services actually furnished or the number of days of care.

PPS was "intended to improve the Medicare program's ability to act as a prudent purchaser of services, and to provide predictability regarding payment amounts for both the Government and hospitals." H.R. Rep. No. 25, 98th Cong., 1st Sess., at 132 (1983). In order to "minimize the disruptions that might otherwise occur because of a sudden change in reimbursement policy," *id.* at 136, Congress decided to provide for a "phase-in" period of

four years, starting with the hospital's first accounting year beginning on or after October 1, 1983.[1] During this transition period, PPS payments were based upon a blend of a hospital's "target amount" (referred to in regulations as the "hospital-specific portion" or "HSP") and a federal amount (the "DRG prospective payment rate"). 42 U.S.C. § 1395ww(d)(1)(A). The hospital-specific portion of this blended rate was to be derived from each hospital's actual operating costs during a designated "base year."

During the first transition year, the hospital-specific rate comprised 75% of the blended payment rate, and the federal portion, 25%. In the second year, the ratio was 50% for each portion. In the third year, the hospital-specific portion comprised 45%, and the federal portion 55% of the PPS transition payment; and in the fourth year, the ratio was 25% hospital-specific and 75% federal. Thereafter, the payment rate was based entirely on the federal rate calculated under PPS, as described above. Thus, until the Medicare reimbursement system no longer depended on some proportion of the hospital-specific cost base — in other words, until the PPS system was completely phased in after the fourth transition year — the amount of reimbursement which a hospital would receive from Medicare depended in part upon the precise calculation of its "allowable costs" for the base year. For the reporting periods between 1982 and 1987, HCFA's determination of what was and was not included in the hospital's cost base had a significant impact on the amount hospitals were reimbursed during the transition period.

Congress recognized that adjustments and modifications to the base year costs might be necessary. It required the Secretary to update the costs for inflation, 42 U.S.C. § 1395ww(d)(2)(B), and it gave the Secretary the authority to provide for exceptions and adjustments to "take into account the special needs" of regional and national referral centers and sole community hospitals. 42 U.S.C. § 1395ww(d)(5)(C). Congress also required the Secretary to provide for exceptions and adjustments "where events beyond the hospital's control or extraordinary circumstances" created a

1. Congress originally intended the phase-in period to last for three years, but in 1986 the period was extended by one more year. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9102(a), 100 Stat. 82, 155 (1986).

distortion in the increase in the hospital's costs. 42 U.S.C. § 1395ww(b)(4)(A).

B. *The Regulations at Issue in This Case*

In September 1983, the Secretary promulgated a series of regulations designed to implement Section 1886(d) of the Medicare Act, which established the new prospective payment system. 42 C.F.R. § 405.470(b)(2), which was redesignated in April 1985 as § 412.2(b)(2), provides that "the full prospective payment amount, as determined under subpart D, E, or G of this part, is made for each stay during which there is at least one Medicare payable day of care." 42 C.F.R. § 412.2(b)(2) (1990). Thus, under § 412.2(b)(2), a hospital will be reimbursed equally for Medicare beneficiaries whose Medicare coverage is not exhausted during their hospital stay and for those Medicare beneficiaries whose coverage *is* exhausted during their stay; in other words, the prospective payment system, which reimburses hospitals on a per discharge basis, treats as equals patients who have enough remaining Medicare payable days to cover their *entire* hospital stay, and those whose remaining Medicare payable days cover as little as *one* day of their entire hospital stay. Under the previous reasonable cost reimbursement system, Medicare reimbursed a hospital only for a patient's Medicare payable days; if the patient exhausted his Medicare payable days during his stay in the hospital, the hospital would have to seek payment either from the patient himself, or from a Medigap insurer to make up the difference. Through § 412.2(b)(2), then, Medicare coverage after the implementation of PPS, and during the transition period to PPS, suddenly included hospital stays which consisted in part of non-payable Medicare days ("exhausted stays"). This had not been the case under the old Medicare system.

Plaintiffs in this case are seven short-term acute care nonprofit hospitals. Their base year for purposes of calculating the hospital-specific portion of their transition payment rates was July 1, 1982 through June 30, 1983. Plaintiffs claim that, because § 412.2(b)(2) was not promulgated until after the hospitals' base year costs had been calculated, there is an inherent cost disparity between the costs which they actually incurred during the transition period, and the hospital-specific portion of their payment rates throughout the transition period. Since the hospital-specific portion of their transition payment rates was based upon their base year

costs, and since exhausted stays were not included in these base year costs, plaintiffs argue that the hospital-specific portion of the transition payment rates was unfairly "diluted." They seek recalculation of their base year costs to include costs incurred during exhausted stays. Plaintiffs insist that it is only through such a recalculation, and its application to HSP rates throughout the transition period, that they will be fairly reimbursed in a manner consistent with Congress' intent.

Discussion

A. *The Appropriate Standard of Review*

The appropriate standard of review is set out at 42 U.S.C. § 1395oo(f)(1), which incorporates the Administrative Procedure Act ("APA") at 5 U.S.C. § 706(2)(A). That standard requires the Court to "hold unlawful and set aside agency action, findings, and conclusions found to be arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law." Thus, the issue before this Court is whether the Secretary's refusal to apply § 412.2(b)(2) to adjust plaintiffs' base year costs is not in accordance with the statutory mandate of 42 U.S.C. §§ 1395ww(b)(4)(A) and (d)(5)(I).

In reviewing an agency's construction of a statute, a court must first determine "whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter." *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842 (1984); *see also Georgetown Univ. Hosp. v. Bowen*, 862 F.2d 323, 326 (D.C. Cir. 1987). Where the statute and the intent behind it are ambiguous with respect to a matter at issue, however, the Court must decide whether the agency's construction of the statute is "based on a permissible construction of the statute." *Chevron*, 467 U.S. at 843. The Court may not substitute its own construction of a statutory provision if the agency's interpretation is "reasonable." *Id.* at 844.

B. *Statutory Language and Legislative History*

Plaintiffs claim that the Secretary's refusal to adjust their base year costs violates 42 U.S.C. § 1395ww(b)(4)(A) and 42 U.S.C. § 1395ww(d)(5)(I). Both of these provisions delineate the authority of the Secretary to provide for adjustments to hospitals' base

year costs. The Court will consider each statutory provision in turn.

1. 42 U.S.C. § 1395ww(b)(4)(A)

42 U.S.C. § 1395ww(b)(4)(A) states:

> The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). . . .

42 U.S.C. § 1395ww(b)(4)(A) (1988). According to plaintiffs, the statute's use of the word "shall" makes this provision mandatory: if the Secretary finds that an "event beyond the hospital's control" or "extraordinary circumstance" has created a distortion in the hospital's costs, the Secretary *must* provide for an adjustment. Both the plain reading of the word "shall" and the legislative history of this provision comport with plaintiffs' understanding. The dictionary defines "shall" as a word "used in laws, regulations, or directives to express what is mandatory." *Webster's Third New International Dictionary* 2085 (1961). Moreover, Congress indicated that, under this provision, "[t]he Secretary of HHS would be *required* to provide for appropriate exemptions, exceptions, and adjustments. . . ." H.R. Conf. Rep. No. 760, 97th Cong., 2d Sess. at 420 (1982) (emphasis added). *See also Sacred Heart Medical Center v. Sullivan*, Nos. 89-7004, 90-6659, 90-7131, 1991 WL 129834, at *5 (E.D. Pa. July 11, 1991). Thus, it is clear from the language and legislative history of the statute that this provision is a mandatory directive to the Secretary.

The question remains, however, whether the Secretary's promulgation of a new regulation which treats exhausted stays differently is an "event beyond the hospital's control or extraordinary circumstance" within the meaning of this subsection. The phrase itself is certainly ambiguous, and surrounding language offers little indication of what Congress meant by an "event beyond the hospital's control or extraordinary circumstances." The only example cited in the section is "changes in the case mix" of the hospital.

Although the legislative history of § 1395ww(b)(4)(A) does not explicitly exclude subsequent changes in agency regulations from the definition of "events beyond the hospital's control or extraordinary circumstances," it does suggest that Congress did not contemplate such a definition. In considering what types of situations would require adjustments under § 1395ww(b)(4)(A) and (d)(5)(I), Congress focused on changes in the nature of services provided, changes in the composition of patients served, and particular difficulties encountered by hospitals located in geographically isolated areas. The Senate committee's discussion of the types of adjustments it envisioned echoes other Congressional committee reports on these provisions:

> The Secretary would be required to provide for exceptions and adjustments to take into account the special circumstances faced by sole community providers. . . .
>
> The committee . . . expects that the Secretary, in making such determinations for sole community providers under the new prospective payment system, will develop and take into account a much broader range of factors relating to beneficiary access to basic hospital services. . . .
>
> Under this amendment, the Secretary would also be required to provide exceptions and adjustments, as he deems appropriate, to take into account the special needs of public or other hospitals that serve a disproportionately large number of low-income and part A Medicare beneficiaries. . . .
>
> Exceptions and adjustments would also be permitted to take into account the special needs of hospitals located in Alaska and Hawaii, as the Secretary now does in applying the reimbursement limits of present law.

S. Rep. 23, 98th Cong., 1st Sess., at 54 (1983); *see also* H. Rep. 25, 98th Cong., 1st Sess., at 154-55 (1983); H. Rep. 760, 97th Cong., 2d Sess., at 420 (1982) (conference report on Tax Equity and Fiscal Responsibility Act). Nowhere in the legislative history of § 1395ww(b)(4)(A) does Congress address the possible interpretation plaintiffs are urging — that the Secretary's promulgation of a regulation which changes the calculation of Medicare reimbursement is sufficient grounds for an adjustment to a hospital's base year costs. Furthermore, the kinds of adjustments that various courts have required the Secretary to make under § 1395ww(b)(4)(A) do not include adjustments based on regulatory changes. Generally, adjustments to base year costs under

this subsection have been mandated only in the context of hospital construction or renovation that occurred after the base year. *See, e.g., Sacred Heart Medical Center v. Sullivan*, 1991 WL 129834 (E.D. Pa. 1991) (court required adjustment under § 1395ww(b)(4)(A) where hospital's base year costs did not reflect new additional facility that had opened after calculation of its base year costs); *Newport Hospital and Clinic, Inc. v. Sullivan*, No. 88-1490, 1990 WL 179953 (D.D.C. 1990) (hospital which undertook construction would be allowed to have its Medicare hospital-specific rates retroactively adjusted because this was "extraordinary circumstance" contemplated by statute). Thus, the Court must conclude that, at the very least, it is unclear from the language of the statute and its legislative history whether Congress intended the Secretary to make the kinds of adjustments plaintiffs demand under § 1395ww(b)(4)(A). The Court's review of the Secretary's refusal to make the adjustments will therefore be limited to a determination of whether this refusal was reasonable.

2. *42 U.S.C. § 1395ww(d)(5)(I)*

Section 1395ww(d)(5)(I) is a catch-all provision for adjustments that delegates decision-making authority to the Secretary: "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate." 42 U.S.C. § 1395ww(d)(5)(I) (1988). Plaintiffs' reliance on this provision to demonstrate a statutory mandate directing the Secretary to make certain adjustments is entirely misplaced. By its very terms, § 1395ww(d)(5)(I) leaves the decision of whether or not to grant an adjustment in the Secretary's hands; he need only make those exceptions that he "deems appropriate." Thus, as to this statutory provision as well, the Court's review will be limited to the question of whether the Secretary's exercise of discretion was reasonable.

C. *The Secretary's Refusal to Adjust Plaintiffs' Base Year Costs*

The Secretary argues that § 1395ww(b)(3)(A) directs him to calculate the hospital-specific portion of reimbursement rates during the transition period to PPS on the basis of "allowable operating costs of in-patient hospital services . . . recognized under this title for such hospital for the preceding 12-month cost

reporting period. . . ." 42 U.S.C. § 1395ww(b)(3)(A) (1988). In other words, the Secretary claims he is limited, in calculating the base year costs, and any adjustment to those costs, by the term "allowable costs": only if a cost is "allowable" can the Secretary include it in the base year. The Secretary further argues that the term "allowable costs" refers exclusively to those costs that would have been reimbursed under the old "reasonable cost" Medicare system. Because under the reasonable cost system Medicare did not cover hospital stays where beneficiaries' days of covered services were exhausted, the Secretary concludes that those kinds of costs are simply not "allowable," notwithstanding any subsequent change in regulatory policy.

The broader issue here is whether the hospital-specific portion of hospitals' transition period payments is retrospective or prospective. Plaintiffs argue that it is prospective: Congress included the hospital-specific portion to ease hospitals' transition to the new payment system, and allowed adjustments to hospitals' base years to ensure that the hospital-specific rate would more closely reflect costs that would be paid under the prospective payment system. The Secretary insists that the hospital-specific portion must be retrospective because it is based on hospitals' *historical* costs, not their projected costs under the new system. Under this retrospective interpretation, adjustments serve the purpose of correcting mistaken calculations as to what was and was not considered "allowable" under the reasonable cost system.

Although the Court does not agree that *all* adjustments to hospitals' base year costs must be limited to "allowable costs," the Court does find that the adjustments sought in this case must be limited to "allowable costs." This Circuit has recently had occasion to consider the interpretation of "allowable costs" under § 1395ww(b)(3)(A) and how that phrase affects adjustments to hospitals' base year costs. In *Georgetown Univ. Hosp. v. Bowen*, 862 F.2d 323 (D.C. Cir. 1988), the Court of Appeals examined the language and legislative history of § 1395ww(b)(3)(A) to determine that "allowable" does refer back to the reasonable cost system:

> In the most direct language, therefore, Congress clearly ordered that costs that were 'allowable' under the old system were to remain a component of payment rates during the phase-in period of the new system. 'Allowable,' in turn, invokes a straightforward concept: if

> the reasonable cost system would have reimbursed a hospital for a given cost, it was 'allowable' and should become a factor in determining a hospital's base year figure.

Georgetown v. Bowen, 862 F.2d at 326. Moreover, the Court of Appeals concluded that Congress, by including a hospital-specific portion in the transition period payment, "signalled an intent to keep certain elements of the former system in place at least temporarily — elements that would in the end be abandoned altogether, but which were nevertheless included in order to minimize financial disruptions." *Id.* at 327. Thus, this Circuit has interpreted the hospital-specific portion as retrospective rather than prospective.

However, the Secretary's argument that *all* adjustments to a hospital's base year costs must be limited to those costs that were "allowable" under the reasonable cost system cannot succeed. Generally, adjustments to hospitals' base year costs do involve an interpretation of whether the cost would or should have been "allowable" under the reasonable cost system. *See, e.g., St. Mary of Nazareth Hosp. Center v. Heckler*, 760 F.2d 1311 (D.C. Cir. 1985) (labor/delivery room days improperly excluded from allowable cost calculation); *Samaritan Health Serv. v. Bowen*, 811 F.2d 1524 (D.C. Cir. 1987) (sick newborn facility improperly excluded from reimbursement under reasonable cost system). But the language of the statute itself, as well as its legislative history, indicates that Congress intended some costs to be included in a hospital's base year which had not been included under the reasonable cost system. The clearest example of such a cost, and one upon which plaintiffs heavily rely, are FICA taxes. Under the reasonable cost system, Medicare hospitals did not have to pay such taxes; under the prospective payment system, they are required to pay them. Thus, Congress explicitly provided, in 42 U.S.C. § 1395ww(b)(6), for an adjustment to hospitals' base year costs based upon an estimate of FICA tax costs. 42 U.S.C. § 1395ww(b)(6) (1988); *see also* H.R. Conf. Rep. 47, 98th Cong., 1st Sess., at 181-82 (1983) ("The managers recognize that, in some cases, the Secretary will have to use estimates to adjust some portions of the hospital's base year experience to make it comparable to inpatient operating costs that will be paid under the prospective system — e.g. FICA taxes . . .").

Significantly, those cost adjustments, such as the ones for FICA taxes, that do not fall in the "allowable cost" category are separately provided for in the statute, *see, e.g.*, 42 U.S.C. § 1395ww(b)(4)(A) (adjustments required for "events beyond the hospital's control or extraordinary circumstances"); 42 U.S.C. § 1395ww(b)(6) (FICA adjustments); 42 U.S.C. § 1395ww(d)(5)(E)(i) (adjustments for costs of ancillary services previously categorized under Part B of Medicare). The cost adjustments sought here have already been determined not to fall within § 1395ww(b)(4)(A), and it is clear they do not fall within the FICA or ancillary services provisions. Thus, the Secretary was not unreasonable in considering plaintiffs' request for adjustments under the framework of "allowable costs."

Finally, in determining whether the Secretary acted reasonably in this case, the Court considers the following chronology: Plaintiffs' base year was July 1, 1982 through June 30, 1983. The regulation which redefined exhausted stays under Medicare, 42 C.F.R. § 412.2(b)(2), was first promulgated through an interim final rule with comment issued on September 1, 1983, and then through the final rule published on January 1, 1984. Plaintiffs' entire base year thus preceded the issuance of § 412.2(b)(2). In order to increase the hospital-specific portion of plaintiffs' transition payments during the years 1985 through 1988, the Secretary would have to apply § 412.2(b)(2) *retroactively* to recalculate plaintiffs' base year costs. The Supreme Court has made it very clear in *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204 (1988), that, in the absence of express statutory authority, the Secretary may not promulgate rules with retroactive effect. *Bowen*, 488 U.S. at 208. The Supreme Court did not find such express statutory authority for cost limit rules under the Medicare Act in *Bowen;* nor does such express authority exist for the rules promulgated under §§ 1395ww(b) or (d). Moreover, it is difficult for this Court to believe that Congress intended to allow the Secretary to promulgate regulations which would retroactively increase or decrease allowable costs in hospitals' base years.[2]

2. Were this Court to agree that § 412.2(b)(2) should be applied retroactively, it would essentially be giving the Secretary the authority to promulgate other rules that might increase or *decrease* hospitals' base year calculations. The Court suspects that plaintiffs would not be making the same arguments, had the Secretary promulgated and retroactively applied a regulation in late 1983 which would have *decreased* plaintiffs' base year costs.

Plaintiffs claim that they are merely seeking retroactive case-by-case cost adjustments and not retroactive application of a rule. They rely on *Bowen*'s statement that the Medicare Act allows "case-by-case adjustments to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases." *Bowen*, 488 U.S. at 209. However, plaintiffs are not arguing in this case that § 412.2(b)(2) was misapplied in their cases they are arguing that the regulation was not applied at all when it should have been. Moreover, plaintiffs cannot limit the application of § 412.2(b)(2) to their own case; if § 412.2(b)(2) requires recalculation of plaintiffs' base year costs, it requires recalculation of the base year costs of *every* hospital which did not get Medicare reimbursement for exhausted stays in its base year. Had the Secretary done what plaintiffs are seeking in this action, he would have had to apply his rule retroactively, in violation of the Supreme Court's mandate in *Bowen*. The Court cannot find that his refusal to do so was unreasonable.

D. *Equal Protection and Substantive Due Process Claims*

Plaintiffs' final claim is that the Secretary' approach to granting adjustments violates principles of equal protection and substantive due process embodied in the Due Process Clause of the Fifth Amendment. Plaintiffs argue that, by granting adjustments for FICA taxes and anciliary hospital services but refusing the adjustments sought here, the Secretary purposefully and arbitrarily sought to benefit certain classes of hospitals and disadvantage others. This claim has no merit. The FICA and ancillary services adjustments cited by plaintiffs were specifically mandated by Congress. *See* 42 U.S.C. § 1395ww(b)(6) and § 1395ww(d)(5)(E)(i). As discussed above, Congress gave the Secretary the discretion to grant or deny other adjustments not specifically mandated. The Court has determined that the Secretary exercised this discretion reasonably, in a manner rationally designed to achieve the legitimate governmental purposes set out in the Medicare Act. *California v. Aznavorian*, 439 U.S. 170, 174 (1978). Thus, the Secretary's approach does not violate constitutional principles of equal protection and substantive due process.

CONCLUSION

Nothing in the Medicare Act or its legislative history indicates that Congress intended the Secretary to make adjustments to hospitals' base year costs when subsequent regulations redefine Medicare coverage. After reviewing the Secretary's refusal to allow such adjustments, the Court concludes that his action was reasonable. Thus, the Court hereby denies plaintiffs' motion for summary judgment and grants defendant's motion for summary judgment. An order consistent with this Memorandum Opinion will be entered this day.

/s/ NORMA HOLLOWAY JOHNSON

NORMA HOLLOWAY JOHNSON
UNITED STATES DISTRICT JUDGE

Dated: November 12, 1991

APPENDIX D

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

CIVIL ACTION NO. 89-1716

EPISCOPAL HOSPITAL, ET. AL., PLAINTIFFS,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT.

NOVEMBER 12, 1991

ORDER AND JUDGMENT

Upon consideration of the motion of plaintiffs for summary judgment, the motion of defendant for summary judgment, the submissions of the parties, the record as a whole, and consistent with the accompanying Memorandum Opinion, it is this 12th day of November, 1991,

ORDERED that the motion of plaintiffs for summary judgment be, and hereby is, denied; and it is further

ORDERED that the motion of defendant for summary judgment be, and hereby is, granted; and it is further

ORDERED that judgment be, and hereby is, entered in favor of defendant.

/s/ NORMA HOLLOWAY JOHNSON

NORMA HOLLOWAY JOHNSON
UNITED STATES DISTRICT JUDGE

APPENDIX E

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

CIVIL ACTION NO. 91-1657 (NHJ)

EPISCOPAL HOSPITAL, ET AL., PLAINTIFFS,

v.

LOUIS SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT.

December 18, 1991

STIPULATED ORDER AND JUDGMENT

JOHNSON, District Judge.

Plaintiffs Episopal Hospital et al. ("Plaintiff-Hospitals") and Defendant, Louis W. Sullivan, M.D., Secretary of Health and Human Services (the "Secretary"), by and through their undersigned counsel, hereby agree and stipulate as follows:

WHEREAS in Civil Action No. 89-1716 (NHJ), Plaintiff-Hospitals challenged a refusal by the Secretary to adjust the hospital-specific portion of their Medicare prospective payment rates on appeals from determinations of the Provider Reimbursement Review Board ("PRRB") for their fiscal years ending 1985, 1986, and 1987.

WHEREAS Plaintiff-Hospitals filed Civil Action No. 91-1657 (NHJ) as a related action to No. 89-1716 raising the identical claims on appeal from the PRRB with respect to their fiscal year ending 1988.

WHEREAS at a status conference held on October 18, 1991 the Parties jointly requested the Court to stay further action in No. 91-1657 (NHJ) pending disposition of cross-motions for summary judgment in No. 89-1716, given the likelihood that the decision in the first case would be controlling.

WHEREAS the Court rendered a Memorandum Opinion and an Order and Judgment on November 12, 1991 granting summary judgment to the Secretary and denying summary judgment to Plaintiff-Hospitals.

WHEREAS the Court has noticed a status call in No. 91-1657 for December 13, 1991 and the parties wish to deal efficiently, economically and expeditiously with these cases.

WHEREFORE the parties hereby jointly agree to stipulate and request the Court to enter, as an Order and Final Judgment resolving No. 91-1657, the following:

1. The Memorandum Opinion and Order and Judgment filed on November 12, 1991 in No. 89-1716 shall be treated as dispositive of No. 91-1657, which involves the identical parties and the identical legal issues for a more recent fiscal year.

2. Judgment shall be entered for the Secretary and against the Plaintiff-Hospitals for the reasons supporting the Court's disposition of No. 89-1716, as set forth in the Court's Memorandum Opinion in No. 89-1716.

3. This Stipulation is not, nor is it intended by the Plaintiff-Hospitals as, a concession as to the merits of the Court's decision in No. 89-1716 or a waiver of the right to appeal in either case, which right to appeal is expressly reserved.

Respectfully submitted,

For the Plaintiffs Hospitals:

/s/ MARK H. GALLANT, ESQUIRE

Mark H. Gallant, Esquire
D.C. Bar No. 913111
WOLF, BLOCK, SCHORR
and SOLIS-COHEN
Twelfth Floor Packard Building
15th & Chestnut Streets
Philadelphia, PA 19102
(215) 977-2008

For the Secretary:

/s/ LINDA RUIZ, ESQUIRE

Linda Ruiz, Esquire
D.C. Bar No. 318386
Office of the General Counsel
DEPARTMENT OF
HEALTH & HUMAN
SERVICES
Room 500,
East High Rise Building
Baltimore, MD 21207
(301) 965-8865

OF COUNSEL:

Robert C. Seldon, Esquire
D.C. Bar No. 245100
KROOTH & ALTMAN
2101 L Street, N.W.
Suite 210
Washington, D.C. 20037
(202) 293-8200

The foregoing Stipulation is hereby APPROVED, and it is hereby ORDERED that Judgment shall be entered for the Defendant and against the Plaintiffs.

December 18, 1991	/s/ NORMA HOLLOWAY JOHNSON
Dated	By: U.S.D.J.

APPENDIX F

PROVIDER REIMBURSEMENT REVIEW BOARD

CASE NO. 89-5037G

PHILADELPHIA HOSPITALS GROUP APPEAL

FYE JUNE 30, 1986 AND JUNE 30, 1987

May 8, 1990

BOARD DETERMINATION

Mark H. Gallant, Esquire
Wolf, Block, Schorr and Solis-Cohen
Twelfth Floor Packard Building
S.E. Corner 15th and Chestnut Streets
Philadelphia, PA 19102-2678

Dear Mr. Gallant:

Re: Philadelphia Hospitals Group Appeal, Case No. 89-5037G, FYE — June 30, 1986, and June 30, 1987, Request for A Board Determination that It Lacks the Authority to Decide Whether the Hospital Specific Rate Should Have Been Increased Throughout the PPS Transition Period to Account for the Base-Year Costs Incurred in Treating Beneficiaries After the Post-Admission Expiration of Their Medicare Coverage

This is in response to your request that the Provider Reimbursement Review Board (Board), pursuant to 42 USC 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the question of whether the hospital specific rate should have been increased throughout the PPS transition period to account for the base-year costs incurred for the above type of modification. The above-cited statutory provision permits a provider that requested and is entitled to a hearing before the Board,

under USC 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation where the Board determines that it is without authority to decide such question.

The Board has reviewed the Providers' submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $50,000 and is approximately $474,000 for FYE June 30, 1986, and $426,000 for FYE June 30, 1987. The estimated amount in controversy is subject to recalculation by the intermediary for the actual final amount.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject years and that the Providers are entitled to a hearing before the Board;
2. That based upon the Providers' assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulations (42 CFR 405.1867); and
4. That the Board is without authority to decide the legal question of whether the Medicare regulations governing the reimbursement for the above issue (42 CFR 412.71(b) and 412.71(c) are valid.

Accordingly, the Board finds that this case properly falls within 42 USC 1395oo(f)(1) and hereby grants the Providers' requests for expedited judicial review for the above stated issue for the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

Elise D. Smith
Arthur P. Owens
Keith E. Braganza
Sally A. Kirkpatrick
Joseph F. Sloan

FOR THE BOARD:

/s/ Keith E. Braganza
Board Member

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended
Schedule of Participating Providers

cc: William Braggs, BC&BSA
Bernard Talbert, BC&BSA
Charles Knowlton, Aetna

APPENDIX G

PROVIDER REIMBURSEMENT REVIEW BOARD

CASE NO. 90-1920G
PHILADELPHIA HOSPITALS GROUP APPEAL
FYE JUNE 30, 1988

May 6, 1991

BOARD DETERMINATION

Mark H. Gallant, Esquire
Wolf, Block, Schorr and Solis-Cohen
Twelfth Floor Packard Building
S.E. Corner 15th and Chestnut Streets
Philadelphia, PA 19102-2678

Dear Mr. Gallant:

Re: Philadelphia Hospitals Group Appeal, Case No. 90-1920G, FYE — June 30, 1988, Request for A Board Determination that It Lacks the Authority to Decide Whether the Hospital Specific Rate Should Have Been Increased Throughout the PPS Transition Period to Account for the Base-Year Costs Incurred in Treating Beneficiaries After the Post-Admission Expiration of Their Medicare Coverage

This is in response to your request of April 22, 1991, that the Provider Reimbursement Review Board (Board), pursuant to 42 USC 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the question of whether the hospital specific rate should have been increased throughout the PPS transition period to account for the base-year costs incurred for the above type of modification. The above-cited statutory provision permits a provider that requested and is entitled to a hearing before the Board, under USC 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving

a question of law or regulation where the Board determines that it is without authority to decide such question.

The Board has reviewed the Providers' submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for the providers on the enclosed schedule exceeds $50,000 and is approximately $237,000. The estimated amount in controversy is subject to recalculation by the intermediary for the actual final amount.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject year and that the Providers on the enclosed schedule are entitled to a hearing before the Board;
2. That based upon the Providers' assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulation (42 CFR 405.1867); and
4. That the Board is without authority to decide the legal question of whether the Medicare regulations governing the reimbursement for the above issue (42 CFR 412.71(b) and 412.71(c) are valid.

Accordingly, the Board finds that this case properly falls within 42 USC 1395oo(f)(1) and hereby grants the Providers' requests for expedited judicial review for the above stated issue for the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

Keith E. Braganza
Sally A. Kirkpatrick
Joseph F. Sloan
Juanita Petti-Hankins

FOR THE BOARD:

/s/ Keith E. Braganza
Board Member

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended
Schedule of Participating Providers

cc: BCBSA
Aetna

APPENDIX H

PROVIDER REIMBURSEMENT REVIEW BOARD

CASE NO. 87-5007G

PHILADELPHIA HOSPITALS GROUP APPEAL

FYE JUNE 30, 1985

April 12, 1989

BOARD DETERMINATION

Mark H. Gallant, Esquire
Wolf, Block, Schorr and Solis-Cohen
Twelfth Floor Package Building
S.E. Corner 15th and Chestnut Streets
Philadelphia, PA 19102-2678

Re: Philadelphia Hospitals Group Appeal, Case No. 87-5007G, FYE — June 30, 1985, Request for A Board Determination that It Lacks the Authority to Decide Whether the Hospital Specific Rate Should Have Been Increased Throughout the PPS Transition Period to Account for the Base-Year Costs Incurred in Treating Beneficiaries After the Post-Admission Expiration of Their Medicare Coverage

This is in response to your request that the Provider Reimbursement Review Board (Board), pursuant to 42 USC 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the question of whether the hospital specific rate should have been increased throughout the PPS transition period to account for the base-year costs incurred for the above type of modification. The above-cited statutory provision permits a provider that requested and is entitled to a hearing before the Board, under USC 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of

law or regulation where the Board determines that it is without authority to decide such question.

The Board has reviewed the Providers' submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $50,000 and is approximately $700,000. The estimated amount in controversy is subject to recalculation by the intermediary for the actual final amount.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject year and that the Providers are entitled to a hearing before the Board;
2. That based upon the Providers' assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulations (42 CFR 405.1867); and
4. That the Board is without authority to decide the legal question of whether the Medicare regulations governing the reimbursement for the above issue (42 CFR 412.71(b) and 412.71(c)) are valid.

Accordingly, the Board finds that this case properly falls within 42 USC 1395oo(f)(1) and hereby grants the Providers' requests for expedited judicial review for the above stated issue for the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

Arthur P. Owens
Keith E. Braganza
Sally A. Kirkpatrick

/s/ Arthur P. Owens
Acting Chairman

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended
Schedule of Participating Providers

cc: Michael Harty, BC&BSA
Bernard Talbert, BC&BSA
Charles Knowlton, Aetna

APPENDIX I

STATUTORY PROVISIONS

§ 1395ww. Payments to hospitals for inpatient hospital services

(a) Determination of costs for inpatient hospital services; limitations; exemptions; "operating costs of inpatient hospital services" defined

(1)(A)(i) The Secretary, in determining the amount of the payments that may be made under this subchapter with respect to operating costs of inpatient hospital services (as defined in paragraph (4)) shall not recognize as reasonable (in the efficient delivery of health services) costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage (as determined under clause (ii)) of the average of such costs for all hospitals in the same grouping as such hospital for comparable time periods.

(ii) For purposes of clause (i), the applicable percentage for hospital cost reporting periods beginning —

(I) on or after October 1, 1982, and before October 1, 1983, is 120 percent;

(II) on or after October 1, 1983, and before October 1, 1984, is 115 percent; and

(III) on or after October 1, 1984, is 110 percent.

(B)(i) For purposes of subparagraph (A) the Secretary shall establish case mix indexes for all short-term hospitals, and shall set limits for each hospital based upon the general mix of types of medical cases with respect to which such hospital provides services for which payment may be made under this subchapter.

(ii) The Secretary shall set such limits for a cost reporting period of a hospital —

(I) by updating available data for a previous period to the immediate preceding cost reporting period by the estimated average rate of change of hospital costs industry-wide, and

(II) by projecting for the cost reporting period by the applicable percentage increase (as defined in subsection (b)(3)(B) of this section).

(C) The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this subchapter for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

(D) Subparagraph (A) shall not apply to cost reporting periods beginning on or after October 1, 1983.

(2) The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account —

(A) the special needs of sole community hospitals, of new hospitals, of risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital's control, medical and paramedical education costs, significantly fluctuating population in the service area of the hospital, and unusual labor costs,

(B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter, and

(C) a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

(3) The limitation established under paragraph (1)(A) shall not apply with respect to any hospital which —

(A) is located outside of a standard metropolitan statistical area, and

(B)(i) has less than 50 beds, and

(ii) was in operation and had less than 50 beds on September 3, 1982.

(4) For purposes of this section, the term "operating costs of inpatient hospital services" includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are

determined on an average per admission or per discharge basis (as determined by the Secretary). Such term does not include costs of approved educational activities, a return on equity capital, or, other capital-related costs (as defined by the Secretary for periods before October 1, 1987).

(b) Computation of payment; definitions; exemptions; adjustments

(1) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, if the operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B) of this section) for a cost reporting period subject to this paragraph —

(A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A of this subchapter on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus —

(i) 50 percent of the amount by which the target amount exceeds the amount of the operating costs, or

(ii) 5 percent of the target amount,

whichever is less; or

(B) are greater than the target amount, the amount of the payment with respect to such operating costs payable under part A of this subchapter on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1991, an additional amount equal to 50 percent of the amount by which the operating costs exceed the target amount (except that such additional amount may not exceed 10 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period;

except that in no case may the amount payable under this subchapter (other than on the basis of a DRG prospective payment rate determined under subsection (d) of this section) with respect

to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a) of this section.

(2) Repealed. Pub.L. 98-21, Title VI, § 601(b)(4), Apr. 20, 1983, 97 Stat. 150

(3)(A) Except as provided in subparagraphs (C), (D), and (E), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period —

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

* * * * * * * * * * * * * *

(4)(A) The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services. The Secretary shall announce a decision on any request for an exemption, exception,

or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.

(B) In determining under subparagraph (A) whether to assign a new base period which is more representative of the reasonable and necessary cost to a hosptial of providing inpatient services, the Secretary shall take into consideration —

(i) changes in applicable technologies and medical practices, or differences in the severity of illness among patients, that increase the hospital's costs;

(ii) whether increases in wages and wage-related costs for hospitals located in the geographic area in which the hospital is located exceed the average of the increases in such costs paid by hospitals in the United States; and

(iii) such other factors as the Secretary considers appropriate in determining increases in the hospital's costs of providing inpatient services.

(C) Paragraph (1) shall not apply to payment of hospitals which is otherwise determined under paragraph (3) of section 1395f(b) of this title.

* * * * * * * * * * * * * *

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographic Classification Review Board

(1)(A) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year —

(i) beginning on or after October 1, 1983, and before October 1, 1984, is equal to the sum of —

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period

(as defined in subsection (b)(3)(A) of this section, but determined without the application of subsection (a) of this section), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, 1987, is equal to the sum of —

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A) of this section, but determined without the application of subsection (a) of this section), and

(II) the DRG percentage (as defined in subparagraph (c)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after April 1, 1988, and ending on September 30, 1993, the sum of (I) 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, and (II) 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph.

(B) As used in this section, the term "subsection (d) hospital" means a hospital located in one of the fifty States or the District of Columbia other than —

(i) a psychiatric hospital (as defined in section 1395x(f) of this title),

(ii) a rehabilitation hospital (as defined by the Secretary),

(iii) a hospital whose inpatients are predominately individuals under 18 years of age,

(iv) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, or

(v) a hospital that the Secretary has classified, at any time on or before December 31, 1991,[1] (or, in the case of a hospital that, as of December 19, 1989, is located in a State operating a demonstration project under section 1395f(b) of this title, on

or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer;

and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary).

(C) For purposes of this subsection, for cost reporting periods beginning —

(i) on or after October 1, 1983, and before October 1, 1984, the "target percentage" is 75 percent and the "DRG percentage" is 25 percent;

(ii) on or after October 1, 1984, and before October 1, 1985, the "target percentage" is 50 percent and the "DRG percentage" is 50 percent;

(iii) on or after October 1, 1985, and before October 1, 1986, the "target percentage" is 45 percent and the "DRG percentage" is 55 percent; and

(iv) on or after October 1, 1986, and before October 1, 1987, the "target percentage" is 25 percent and the "DRG percentage" is 75 percent.

(D) For purposes of subparagraph (A)(ii)(II), the "applicable combined adjusted DRG prospective payment rate" for discharges occurring —

(i) on or after October 1, 1984, and before October 1, 1986, is a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate, and 75 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges; and

(ii) on or after October 1, 1986, and before October 1, 1987, is a combined rate consisting of 50 percent of the national adjusted DRG prospective payment rate, and 50 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges.

(5)(A)(i) The Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis-related group, the length of stay of which exceeds the mean length of stay for discharges within that group by a fixed number of days,

or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

(ii) For cases which are not included in clause (i), a subsection (d) hospital may request additional payments in any case where charges, adjusted to cost, exceed a fixed multiple of the applicable DRG perospective payment rate, or exceed such other fixed dollar amount, whichever is greater.

(iii) The amount of such additional payment under clauses (i) and (ii) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i) or (ii).

(iv) The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

* * * * * * * * * * * * * *

(E)(i) The Secretary shall estimate the amount of reimbursement made for services described in section 1395y(a)(14) of this title with respect to which payment was made under part B of this subchapter in the base reportng periods referred to in paragraph (2)(A) and with respect to which payment is no longer being made.

(ii) The Secretary shall provide for an adjustment to the payment for subsection (d) hospitals in each fiscal year so as appropriately to reflect the net amount described in clause (i).

* * * * * * * * * * * * * *

(I) The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

APPENDIX J

REGULATIONS

---

42 C.F.R. § 412.2

§ 412.2 Basis of payment.

* * * * * * * * * * * * * *

(b) *Payment in full.* (1) The prospective payment amount paid for inpatient hospital services is the total Medicare payment for the inpatient operating costs (as described in paragraph (c) of this section) incurred in furnishing services covered by the Medicare program.

(2) The full prospective payment amount, as determined under subpart D, E, or G of this part, is made for each stay during which there is at least one Medicare payable day of care. Payable days of care, for purposes of this paragraph (b)(2), include the following:

(i) Waiver of liability days payable under § 405.330 of this chapter.

(ii) Guarantee of payment days, as authorized under § 409.68 of this chapter, for inpatient hospital services furnished to an individual whom the hospital has reason to believe is entitled to Medicare benefits at the time of admission.

42 C.F.R. § 412.70

§ 412.70 General description.

(a) *Basic rules.* (1) During the initial four-year transition period, payments to all hospitals paid under the prospective payment system are based on a combination of the Federal prospective payment rates, as determined under subpart D of this part, and hospital-specific rates determined under this subpart.

(2) For the first two years of the transition period, both portions of the payment rates are also adjusted to ensure budget neutrality.

(3) At the end of the transition period (that is, for cost reporting periods beginning on or after October 1, 1987), payments are based on the national prospective payment rates determined under supbart D of this part, except for payments that may be made under the special treatment provisions of subpart G of this part.

(b) *Payment amounts based on the hospital-specific portion and the Federal portion.* For discharges occurring in cost reporting periods beginning on or after October 1, 1983 and before October 1, 1987, the Medicare transition payment rate for a particular covered discharge equals a blend of the applicable portion of the hospital-specific rate, as determined under § 412.73, plus the applicable portions of the Federal national and regional prospective payment rates, as described in paragraph (c) of this section, and summarized in the Table. Payments to new hospitals are based on the Federal national and regional prospective payment rates, as described in paragraph (d) of this section.

(c) *Amount of blended portions.*[1] The blends of hospital-specific and Federal portions are as follows:

(1) For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984, the blend is —

(i) 75 percent of the hospital-specific rate; and

(ii) 25 percent of the appropriate Federal prospective payment rate.

(2) For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1985, the blend is —

(i) 50 percent of the hospital-specific rate; and

(ii) 50 percent of the appropriate Federal prospective payment rate.

(3) For cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the blend is as follows:

(i) For the first seven months of the cost reporting period, the blend is —

(A) 50 percent of the hospital-specific rate; and

(B) 50 percent of the appropriate Federal prospective payment rate.

(ii) For the remaining five months of the cost reporting period, the blend is —

(A) 45 percent of the hospital-specific rate; and

(B) 55 percent of the appropriate Federal prospective payment rate.

(4) For cost reporting periods beginning on or after October 1, 1986 and before October 1, 1987, the blend is —

(i) 25 percent of the hospital-specific rate; and

(ii) 75 percent of the appropriate Federal prospective payment rate.

(5) The appropriate Federal prospective payment rate is a combined regional and national rate and changes with the Federal fiscal year. For Federal fiscal year 1984, which begins October 1, 1983, the Federal prospective payment rate is 100 percent regional. For Federal fiscal years 1985 and 1986, which begin October 1, 1984 and October 1, 1985, respectively, the combined rate is 75 percent regional and 25 percent national. For Federal fiscal year 1987, which begins October 1, 1986, the combined rate is 50 percent regional and 50 percent national. Effective with Federal fiscal year 1988, which begins October 1, 1987, the Federal prospective payment rate is 100 percent national except as provided in paragraph (c)(6) of this section.

(6) For discharges occurring on or after April 1, 1988 and before October 1, 1990, payments to a hospital are based on the greater of the national average standarized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region in which the hospital is located.

TABLE — SUMMARY OF HOSPITAL-SPECIFIC AND FEDERAL PORTION PERCENTAGES FOR DETERMINING TRANSITION PAYMENT RATES

Cost reporting period beginning on or after	Hospital-specific portion percentage	Federal portion percentage*
October 1, 1983	75	25
October 1, 1984	50	50
October 1, 1985 —		
The first seven months of the cost reporting period	50	50
The remaining five months of the cost reporting period	45	55
October 1, 1986	25	75
October 1, 1987	0	100

* NOTE: The Federal portion percentages are applied to the combined national or regional prospective payment rates, as appropriate, as determined under Subpart D of this part for the Federal fiscal year in which discharge occurs.

(d) *Blended portions for new hospitals.* The prospective payment rates for new hospitals are a blend of the Federal regional and national rates as follows:

(1) For discharges occurring on or after October 1, 1983, and before October 1, 1984, the prospective payment rate equals the appropriate Federal regional rate.

(2) For discharges occurring on or after October 1, 1984 and before October 1, 1986, the prospective payment rate is a blend of —

(i) 75 percent of the appropriate Federal regional prospective payment rate; and

(ii) 25 percent of the appropriate Federal national rate.

(3) For discharges occurring on or after October 1, 1986 and before October 1, 1987, the prospective payment rate is a blend of —

(i) 50 percent of the appropriate Federal regional prospective payment rate; and

(ii) 50 percent of the appropriate Federal national prospective payment rate.

(4) For discharges occurring on or after October 1, 1987, the prospective payment rate equals the appropriate Federal national rate except as provided in paragraph (d)(5) of this section.

(5) For discharges occurring on or after April 1, 1988 and before October 1, 1990, payments to a hospital are based on the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region in which the hospital is located.

[51 FR 16786, May 6, 1986, as amended at 53 FR 38528, Sept. 30, 1988]

42 C.F.R. § 412.71

§ 412.71 Determination of base-year costs.

(a) *Base-year costs.* (1) For each hospital, the intermediary will estimate the hospital's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1982 and before September 30, 1983.

(2) If the hospital's last cost reporting period ending before September 30, 1983 is for less than 12 months, the base period will be the hospital's most recent 12-month or longer cost reporting period ending before such short reporting period, with an appropriate adjustment for inflation. (The rules applicable to new hospitals are set forth in § 412.74.)

(b) *Modifications to base-year costs.* Prior to determining the hospital-specific rate, the intermediary will adjust the hospital's estimated base-year inpatient operating costs, as necessary, to include malpractice insurance costs as described in § 413.55 of this chapter, and exclude the following:

(1) Nursing differential costs as described in § 405.430[1] of this chapter.

(2) Medical education costs as described in § 413.85 of this chapter.

(3) Capital-related costs are described in § 413.130 of this chapter.

(4) Kidney acquisition costs incurred by hospitals approved as renal transplantation centers as described in § 412.100. Kidney acquisition costs in the base year will be determined by multiplying the hospital's average kidney acquisition cost per kidney times the number of kidney transplants covered by Medicare Part A during the base period.

(5) Higher costs that were incurred for purposes of increasing base-year costs.

(6) One-time nonrecurring higher costs or revenue offsets that have the effect of distorting base-year costs as an appropriate basis for computing the hospital-specific rate.

(7) Higher costs that result from changes in hospital accounting principles initiated in the base year.

(8) For cost reporting periods beginning on or after October 1, 1984 through any part of a cost reporting period occurring before January 1, 1989, the cost of qualified nonphysician anesthetists' services as described in § 412.113(c).

(c) *Hospital's request for adjustment of base-year costs.* (1) Before the date it becomes subject to the prospective payment system, a hospital may request the intermediary to further adjust its estimated base-period costs to take into account the following:

(i) Services paid for under Medicare Part B during the hospital's base year that will be paid for under prospective payments. The base-year costs may be increased to include estimated payments for certain services previously billed as physicians' services before the effective date of § 405.550(b) of this chapter, and estimated payments for nonphysicians' services that were not furnished either directly or under arrangements before October 1, 1983 (the effective date of § 405.310(m) of this chapter), but may not include the costs of anesthetists' services for which a physician employer continues to bill under § 405.553(b)(4) of this chapter.

(ii) The payment of FICA taxes during cost reporting periods subject to the prospective payment system, if the hospital had not paid such taxes for all its employees during its base period and will be required to participate effective January 1, 1984.

(2) If a hospital requests that its base-period costs be adjusted under paragraph (c)(1) of this section, it must timely provide the intermediary with sufficient documentation to justify the adjustment, and adequate data to compute the adjusted costs. The

intermediary will decide whether to use part or all of the data on the basis of audit, survey and other information available.

(d) *Intermediary's determination.* The intermediary will use the best data available at the time in estimating each hospital's base-year costs and the modifications to those costs authorized by paragraphs (b) and (c) of this section. The intermediary's estimate of base-year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided in § 412.72.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 52 FR 33057, Sept. 1, 1987]

42 C.F.R. § 412.72

§ 412.72 Modification of base-year costs.

(a) *Bases for modification of base-year costs.* Base-year costs as determined under § 412.71(d) may be modified under the following circumstances:

(1) *Inadvertent omissions.* (i) A hospital that becomes subject to the prospective payment system beginning on or after October 1, 1983 and before November 16, 1983 has until November 15, 1983 to request its intermediary to reestimate its base-period costs to take into account inadvertent omissions in its previous submissions to the intermediary related to changes made by the prospective payment legislation for purposes of estimating the base-period costs.

(ii) The intermediary may also initiate changes to the estimation —

(A) For any reason before the date the hospital becomes subject to prospective payment; and

(B) Before November 16, 1983, for corrections to take into account inadvertent omissions in the hospital's previous submissions related to changes made by the prospective payment legislation for purposes of estimating the base-period costs.

(iii) Such omissions pertain to adjustments to exclude capital-related costs and the direct medical education costs of approved educational activities and to adjustments specified in § 412.71(c).

(iv) The intermediary must notify the provider of any change to the hospital-specific amount as a result of the provider's request within 30 days of receipt of the additional data.

(v) Any change to base-period costs made under this paragraph (a)(1) will be made effective retroactively, beginning with the first day of the affected hospital's fiscal year.

(2) *Correction of mathematical errors of calculations.* (i) The hospital must report mathematical errors of calculations to the intermediary within 90 days of the intermediary's notification to the hospital of the hospital's payment rates.

(ii) The intermediary may also identify such errors and initiate their correction during this period.

(iii) The intermediary will either make an appropriate adjustment or notify the hospital that no adjustment is warranted within 30 days of receipt of the hospital's report of an error.

(iv) Corrections of errors of calculation will be effective with the first day of the hospital's first cost reporting period subject to the prospective payment system.

(3) *Recognition of additional costs.* (i) The intermediary may adjust base-period costs to take into account additional costs recognized as allowable costs for the hospital's base year as the result of any of the following:

(A) A reopening and revision of the hospital's base-year notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(B) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(C) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of HCFA under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(D) An administrative or judicial review decision under §§ 405.1831, 405.1871, or 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(ii) The intermediary will recalculate the hospital's base-year costs, incorporating the additional costs recognized as allowable for the hospital's base year. Adjustments to base-year costs to take into account these additional costs —

(A) Will be effective with the first day of the hospital's first cost reporting period beginning on or after the date of the revision, order or finding, or review decision; and

(B) Will not be used to recalculate the hospital-specific portion as determined for fiscal years beginning before the date of the revision, order or finding, or review decision.

(4) *Successful appeal.* The intermediary may modify base-year costs to take into account a successful appeal relating to modifications to base-year costs that were made under § 412.71(b). If a hospital successfully contests a modification to base-year costs —

(i) The intermediary will recalculate the hospital's base-year costs to reflect the modification determined appropriate as a result of the appeal; and

(ii) Such adjustments will be effective retroactively to the time of the intermediary's initial estimation of base-year costs.

(5) *Unlawfully claimed costs.* The intermediary may modify base-year costs to exclude costs that were unlawfully claimed as determined as a result of criminal conviction, imposition of a civil judgment under the False Claims Act (31 U.S.C. 3729-3731), or a proceeding for exclusion from the Medicare program. In addition to adjusting base-year costs, HCFA will recover both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates. The amount to be recovered will be computed on the basis of the final resolution of the amount of the inappropriate base-year costs.

(b) *Right to administrative and judicial review.* (1) An intermediary's estimation of a hospital's base-year costs, and modifications, made for purposes of determining the hospital-specific rate, are subject to administrative and judicial review. Review will be available to a hospital upon receipt of its notice of amount of program reimbursement following the close of its cost reporting period, but only with respect to whether the intermediary followed the provisions of §§ 412.71 and 412.72. (Sections 405.1803 and 405.1807 of this chapter set forth the rules for intermediary

determinations and notice of amount of program reimbursement and the effect of those determinations.)

(2) In any administrative or judicial review of whether the intermediary used the best data available at the time, as required by § 412.71(d), an intermediary's estimation will be revised on the basis of this review only if the estimation was unreasonable and clearly erroneous in light of the data available at the time the estimation was made.

(3) Specifically excluded from administrative or judicial review are any issues based on data, information, or arguments not presented to the intermediary at the time of the estimation.

42 C.F.R. § 412.73(a)

§ 412.73 Determination of the hospital-specific rate based on a Federal fiscal year 1982 base period.

(a) *Costs on a per discharge basis.* The intermediary will determine the hospital's estimated adjusted base-year operating cost per discharge by dividing the total adjusted operating costs by the number of discharges in the base period.

(3)

No. 93-429

FILED
DEC 17 1993
OFFICE OF THE CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1993

EPISCOPAL HOSPITAL, ET AL., PETITIONERS

v.

DONNA E. SHALALA,
SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

DREW S. DAYS, III
Solicitor General

FRANK W. HUNGER
Assistant Attorney General

ANTHONY J. STEINMEYER
SCOTT R. MCINTOSH
Attorneys

Department of Justice
Washington, D.C. 20530
(202) 514-2217

BEST AVAILABLE COPY

21 pp

QUESTION PRESENTED

Whether a now-superseded Medicare reimbursement provision, 42 U.S.C. 1395ww(b)(4)(A), was implicitly incorporated into another now-superseded reimbursement provision, 42 U.S.C. 1395ww(d)(1)(A)(i)-(ii), from 1983 to 1987.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statement	2
Argument	7
Conclusion	16

TABLE OF AUTHORITIES

Cases:

Chevron U.S.A. Inc. v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984)	7
Community Hosp. of Chandler, Inc. v. *Sullivan*, 963 F.2d 1206 (9th Cir. 1992)	14
Garcia v. *United States*, 469 U.S. 70 (1984)	10
Good Samaritan Hosp. v. *Shalala*, 113 S. Ct. 2151 (1993)	13
Hillsborough County Hosp. Auth. v. *Shalala*, No. 91-12-CIV-T-21B (M.D. Fla. Nov. 9, 1993)	15
Methodist Hosp. v. *Shalala*, 6 F.3d 829 (D.C. Cir. 1993)	15
Methodist Hosp. v. *Sullivan*, C.A. No. 90-1871-GAG (D.D.C. Sept. 20, 1991)	15
Sacred Heart Medical Center v. *Sullivan*, 958 F.2d 537 (3d Cir. 1992)	8, 10, 11, 13

Statutes and regulations:

Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6003(e)(1)(A)(ii), 103 Stat. 2142	13
Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324	2
§ 101, 96 Stat. 332-334	2
42 U.S.C. 1395c	2
42 U.S.C. 1395f(b)	2, 9
42 U.S.C. 1395x(v)	2, 9

Statutes and regulations—Continued: Page

42 U.S.C. 1395ww(a) 9, 10
42 U.S.C. 1395ww(a)(1) 9
42 U.S.C. 1395ww(a)(4) 9
42 U.S.C. 1395ww(b)(1)(A) 3
42 U.S.C. 1395ww(b)(1)(B) 3
42 U.S.C. 1395ww(b)(3)(A) 2, 5, 7, 8, 9, 10, 12
42 U.S.C. 1395ww(b)(3)(A) (Supp. III 1991) 8
42 U.S.C. 1395ww(b)(3)(A)(i) 2
42 U.S.C. 1395ww(b)(3)(A)(ii) 3
42 U.S.C. 1395ww(b)(3)(C)-(E) (Supp. III 1991) 8
42 U.S.C. 1395ww(b)(4)(A) 3, 6-7, 8, 9, 10, 12, 13, 14, 15, 16
42 U.S.C. 1395ww(d) 3
42 U.S.C. 1395ww(d)(1) 4
42 U.S.C. 1395ww(d)(1)(A)(i)-(ii) 7, 8, 9, 12
42 U.S.C. 1395ww(d)(1)(A)(i)(I) 5
42 U.S.C. 1395ww(d)(1)(A)(i)(II) 5
42 U.S.C. 1395ww(d)(1)(A)(ii)(I) 5
42 U.S.C. 1395ww(d)(1)(A)(ii)(II) 5
42 U.S.C. 1395ww(d)(1)(B) 3
42 U.S.C. 1395ww(d)(1)(C) 5
42 U.S.C. 1395ww(d)(2) 4
42 U.S.C. 1395ww(d)(3) 4
42 U.S.C. 1395ww(d)(4) 4
42 U.S.C. 1395ww(d)(5) 5, 6
42 U.S.C. 1395ww(d)(5)(A)-(H) (Supp. III 1991) 5
42 U.S.C. 1395ww(d)(5)(C)(iii) 13
42 U.S.C. 1395ww(d)(5)(I) (Supp. III 1991) 6, 13
42 U.S.C. 1395ww(g) 4
42 C.F.R.:
Section 412.60 4
Section 412.62 4
Section 412.63 4
Sections 412.70-412.76 6
Section 412.71(b)-(c) 6, 12
Section 412.72(a) 6, 12
Sections 412.300 *et seq.* 4
Section 413.40 3
Section 413.40(c)-(i) 3

Regulations—Continued: Page

Section 413.40(g)(2) 3

Miscellaneous:

48 Fed. Reg. (1993):
p. 39,412 10
p. 39,418 10
49 Fed. Reg. (1984):
p. 234 12
p. 261 12
51 Fed. Reg. (1986):
p. 8208 13
p. 8209 13
H.R. Rep. No. 25, 98th Cong., 1st Sess. (1983) 4
S. Rep. No. 23, 98th Cong., 1st Sess. (1983) 11

In the Supreme Court of the United States

OCTOBER TERM, 1993

No. 93-429

EPISCOPAL HOSPITAL, ET AL., PETITIONERS

v.

DONNA E. SHALALA,
SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-9a) is reported at 994 F.2d 879. The opinion of the district court (Pet. App. 11a-23a) is unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 10a) was entered on June 18, 1993. The petition for a writ of certiorari was filed on September 16, 1993. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Petitioners seek retroactive increases in Medicare reimbursements for certain inpatient hospital care provided during the mid-1980s. Part A of the Medicare program provides elderly and disabled persons with "basic protection against the costs of inpatient hospital services, [related post-hospital,] home health services, and hospice care." 42 U.S.C. 1395c. Prior to 1983, hospital reimbursement under Part A was based primarily on the "reasonable cost" of covered services. 42 U.S.C. 1395f(b). The Medicare program defines "reasonable cost" to mean "the cost actually incurred," exclusive of costs "found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. 1395x(v).

In an effort to curb cost increases and encourage greater efficiency, Congress imposed new limits on Part A reimbursement as part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, 96 Stat. 324. TEFRA left the basic retrospective, cost-based methodology of Part A reimbursement undisturbed, but added financial incentives and penalties to slow the rate of increase in reimbursements for inpatient hospital services. See TEFRA § 101, 96 Stat. 332-334.

TEFRA's rate-of-increase scheme was tied to a "target amount" for each hospital, which was defined in 42 U.S.C. 1395ww(b)(3)(A). For the hospital's initial cost reporting period, Subsection (b)(3)(A) defined "target amount" as "the allowable * * * costs of inpatient hospital services * * * recognized * * * for such hospital for the preceding 12-month cost reporting period." 42 U.S.C. 1395ww(b)(3)(A)(i). For

each subsequent reporting period, the target amount was increased annually by a specified percentage. 42 U.S.C. 1395ww(b)(3)(A)(ii). If a hospital's operating costs were less than the applicable target amount during a reporting period, the hospital received a bonus; conversely, if the hospital's operating costs exceeded the target amount, its reimbursement was reduced. 42 U.S.C. 1395ww(b)(1)(A) and (B); see generally 42 C.F.R. 413.40.

TEFRA also provided for exceptions and adjustments to the rate-of-increase limit on Part A reimbursements, under 42 U.S.C. 1395ww(b)(4)(A). Subsection (b)(4)(A) generally authorized the Secretary to "provide for such * * * exemptions from, and exceptions and adjustments to, [the rate-of-increase reimbursement] method as the Secretary deems appropriate." See generally 42 C.F.R. 413.46(e)-(i). Subsection (b)(4)(A) also specifically directed the Secretary to "provide for an exemption from, or an exception and adjustment to, the [rate-of-increase] method * * * where events beyond the hospital's control or extraordinary circumstances * * * create a distortion in the increase in costs for a cost reporting period." See 42 C.F.R. 413.40(g)(2).

2. In 1983, Congress replaced TEFRA's rate-of-increase limits with a more ambitious and far-reaching reform of Part A reimbursement, the Prospective Payment System (PPS).[1] See 42 U.S.C. 1395ww(d). Under the PPS, hospitals are reimbursed for inpatient costs on the basis of prospectively

[1] Several categories of hospitals have been exempted from the PPS and are still reimbursed under the prior TEFRA provisions. See 42 U.S.C. 1395ww(d)(1)(B). Petitioners do not fall within any of the exemptions and are subject to the PPS.

determined federal rates, rather than actual operating costs. 42 U.S.C. 1395ww(d)(1) and (4); see 42 C.F.R. 412.60.[2] The PPS provides for largely uniform payment rates based on national and regional reimbursement rates for each patient discharge category, known as a "diagnosis-related group" (DRG). 42 U.S.C. 1395ww(d)(2) and (3); see 42 C.F.R. 412.62, 412.63.

Because PPS reimbursement does not depend on an individual hospital's actual costs, reimbursement rates can be determined prospectively. If an individual hospital's costs exceed the prospective federal rates, the hospital must absorb the difference. Conversely, if the hospital's costs are lower than the prospective federal rates, the hospital keeps the difference. This reimbursement scheme was "intended to reform the financial incentives hospitals face, promoting efficiency * * * by rewarding cost[-]effective hospital practices." H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

In order "to minimize disruptions that might otherwise occur because of a sudden change in reimbursement policy," Congress phased in the PPS by creating a four-year transition period from 1983 to 1987. H.R. Rep. No. 25, *supra*, at 136. The reimbursement dispute in this case concerns this now-expired PPS transition period. During the transition period, inpatient hospital services were reimbursed on the basis of blended rates, which consisted of two components. The first component, known as the

---

[2] In October 1991, a separate prospective payment system was established for capital costs. See generally 42 U.S.C. 1395ww(g); 42 C.F.R. 412.300 *et seq.* Those provisions are not at issue here.

"hospital-specific portion" (HSP), was a specified percentage of the hospital's "target amount" for the cost reporting period. 42 U.S.C. 1395ww(d)(1)(A)(i)(I) and (ii)(I). The second component was a percentage of the prospective federal rate under the PPS. 42 U.S.C. 1395ww(d)(1)(A)(i)(II) and (ii)(II). Over the course of the four-year transition period, the portion of the reimbursement amount tied to the prospective rate became progressively larger and the HSP became progressively smaller. The HSP was phased out altogether after 1987, and the prospective rate then formed the exclusive basis for PPS reimbursement. 42 U.S.C. 1395ww(d)(1)(C).

The present case involves the calculation of the HSP's "target amount." To define the "target amount," Congress borrowed the definition it had used earlier in TEFRA, directing the Secretary to use "the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A) of this section * * *)." 42 U.S.C. 1395ww(d)(1)(A)(i)(I) and (ii)(I). Thus, to calculate a hospital's "target amount" during the PPS transition period, the Secretary was required to determine the allowable costs during the 12-month reporting period preceding the first TEFRA year, known as the base year, and then increase that amount by the specified percentages for subsequent periods. See 42 U.S.C. 1395ww(b)(3)(A).

When Congress established the PPS, it provided in 42 U.S.C. 1395ww(d)(5) for various exceptions and adjustments, just as it had done earlier when it enacted TEFRA. That Subsection directed the Secretary to implement a number of specific exceptions and adjustments, 42 U.S.C. 1395ww(d)(5)(A)-(H) (Supp. III 1991), and also granted the Secretary general

authority to establish "such * * * exceptions and adjustments to * * * payment amounts under this subsection as the Secretary deems appropriate," 42 U.S.C. 1395ww (d)(5)(I) (Supp. III 1991). In contrast to TEFRA's analogous provision, however, Subsection (d)(5) does not direct the Secretary to adjust reimbursement amounts where "extraordinary circumstances" distort the increase in costs for a particular cost reporting period.[3]

3. Petitioners are short-term acute care hospitals that receive reimbursement for inpatient care under Part A of the Medicare program. Pet. App. 4a. Petitioners sought increases in their "target amounts" during the PPS transition period on the basis of TEFRA's Subsection (b)(4)(A). Petitioners asserted that a particular change in HHS reimbursement regulations in 1983, which occurred after the hospitals' base year but which would have increased their allowable costs during the base year if it had been in effect at that time, constituted an "event[] beyond the hospital's control or extraordinary circumstance[]" entitling them to an adjustment under TEFRA's Subsection (b)(4)(A).

The district court entered summary judgment in favor of the Secretary. Pet. App. 11a-23a, 24a. The district court assumed, without discussion, that Sub-

---

[3] The PPS's transition-period reimbursement provisions are implemented in regulations found at 42 C.F.R. 412.70-412.76. The regulations specify a limited number of situations in which the "target amount" used to calculate the HSP may be modified to reflect costs other than allowable base year costs. See 42 C.F.R. 412.71(b)-(c), 412.72(a). Notably, the regulations do not authorize modification of the target amount to take into account cost increases occurring after the base year.

section (b)(4)(A) remained in effect during the PPS transition period. The court held, however, that the 1983 regulatory change was not the kind of "event[] beyond the hospital's control or extraordinary circumstance[]" that Congress had meant to address in Subsection (b)(4)(A). Pet. App. 15a-23a.

The court of appeals affirmed. Pet. App. 1a-9a. Applying the principles of *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), the court sustained the Secretary's position that Subsection (b)(4)(A) did not apply during the PPS transition period. Pet. App. 6a-7a. The court held that while the statutory provisions governing the PPS transition period expressly incorporated Subsection (b)(3)(A), which defined "target amount," "[Subsection (b)(3)(A)] plainly d[id] *not* incorporate subsection (b)(4)(A)." Pet. App. 6a. In the alternative, the court held that, "[e]ven if we admit the possibility of other interpretations," the Secretary's reading of the Act "is a permissible one," and therefore must be upheld under *Chevron*. *Id.* at 7a.

ARGUMENT

The decision of the court of appeals is correct, and the question petitioners present is not of substantial continuing importance. Review by this Court therefore is not warranted.

1. a. Petitioners claim that 42 U.S.C. 1395ww (b)(4)(A) entitled them to adjustments in their Medicare reimbursements during the PPS transition period. As the court of appeals recognized, that claim has no basis in the statutory text. The specific provision governing reimbursement during the PPS transition period, 42 U.S.C. 1395ww(d)(1)(A)(i)-(ii),

made no reference whatsoever to Subsection (b)(4)(A). Congress explicitly incorporated into the PPS transition-period rules a different TEFRA provision, Subsection (b)(3)(A), which defined "target amount" under TEFRA. See 42 U.S.C. 1395ww(d)(1)(A)(i)-(ii); Pet. App. 6a-7a. Congress's explicit incorporation of Subsection (b)(3)(A), without reference to Subsection (b)(4)(A), greatly undermines petitioners' argument that Congress meant to incorporate the latter provision as well. See *Sacred Heart Medical Center* v. *Sullivan*, 958 F.2d 537, 545-546 & n.15 (3d Cir. 1992).

Petitioners assert (Pet. 12-13) that Subsection (b)(4)(A) is an integral part of the definition of "target amount" in Subsection (b)(3)(A). However, Subsection (b)(4)(A) did not purport to define "target amount" or to modify the definition of "target amount" found in Subsection (b)(3)(A). Instead, accepting that definition as a given, it authorized the Secretary to create "exemptions from, and exceptions and adjustments to," the "target amount." 42 U.S.C. 1395ww(b)(4)(A); see Pet. App. 6a.

When Congress wished to modify Subsection (b)(3)(A)'s basic definition of "target amount" by incorporating other statutory provisions, it said so explicitly in Subsection (b)(3)(A) itself. Thus, Subsection (b)(3)(A) begins with the proviso that, "[e]xcept as provided in subparagraphs (C), (D), and (E), * * * the term 'target amount' means [allowable operating costs during the base period]." 42 U.S.C. 1395ww(b)(3)(A) (Supp. III 1991).[4] Because Subsection

[4] The cited provisions modify the definition of "target amount" in particular circumstances, none of which applies here. See 42 U.S.C. 1395ww(b)(3)(C)-(E) (Supp. III 1991).

section (b)(4)(A) did not similarly alter or otherwise affect the basic definition of "target amount" in Subsection (b)(3)(A), it was not incorporated into the PPS when Congress directed the Secretary to use "the hospital's target amount * * * as defined in subsection (b)(3)(A)." 42 U.S.C. 1395ww(d)(1)(A)(i)-(ii).

b. Petitioners attempt to reinforce their Subsection (b)(4)(A) incorporation theory by pointing to a wholly separate statutory provision, 42 U.S.C. 1395ww(a). Subsection (a) provided that certain costs "shall not [be] recognize[d] as reasonable," and further prescribed what costs were to be treated as allowable costs under Medicare's general "reasonable cost" reimbursement standard. 42 U.S.C. 1395ww (a)(1) and (4); see generally 42 U.S.C. 1395f(b), 1395x(v). When Congress established the PPS transition period, it directed the Secretary to base reimbursement on the hospital's target amount "as defined in subsection (b)(3)(A) of this section, *but determined without the application of subsection (a)*." 42 U.S.C. 1395ww(d)(1)(A)(i)-(ii) (emphasis added). Petitioners argue that if Congress had meant for the Secretary to determine reimbursement solely on the basis of Subsection (b)(3)(A), without reference to other provisions such as Subsection (b)(4)(A), Congress would have had no reason explicitly to exclude Subsection (a) in this fashion. Petitioners reason that because Congress did not explicitly exclude Subsection (b)(4)(A), as it did Subsection (a), Congress meant implicitly to include Subsection (b)(4)(A). See Pet. 13-14.

This argument fails because Subsection (a), unlike Subsection (b)(4)(A), directly affects the definition of "target amount" in Subsection (b)(3)(A). Subsection

(b)(3)(A) defines "target amount" in terms of "the allowable * * * costs of inpatient hospital services" during the base year. 42 U.S.C. 1395ww(b)(3)(A). Subsection (a) of 42 U.S.C. 1395ww is one of many statutory provisions in the Medicare program that prescribes the "allowable costs" of inpatient hospital services. See generally 48 Fed. Reg. 39,412, 39,418 (1983) (explaining how cost limits under Subsection (a) affected the target amount under Subsection (b)(3)(A)). Because Subsection (b)(3)(A)'s definition of "target amount" turns on "allowable costs," and because Subsection (a) affected which costs were allowable, Congress had to exclude Subsection (a) in order to prevent it from affecting the determination of the "target amount" during the PPS transition period. In contrast, Subsection (b)(4)(A) does not affect the definition of "target amount," and Congress therefore did not have to exclude it affirmatively in order to prevent it from applying to the PPS transition period. See *Sacred Heart*, 958 F.2d at 546 n.18.

c. Petitioners further argue (Pet. 14-15) that the decision of the court of appeals is at odds with the legislative history. Given the clarity with which Congress spoke when it directed the Secretary to use the "target amount * * * as defined in subsection (b)(3)(A)," petitioners face a substantial burden in mining the legislative history to establish that Congress meant to incorporate Subsection (b)(4)(A) *sub silentio*. When a statute is unambiguous, "only the most extraordinary showing of contrary intentions" from the legislative history could justify a departure from the statutory text. *Garcia* v. *United States*, 469 U.S. 70, 75 (1984).

Petitioners point to a brief passage in the Conference Report on the PPS legislation and fragmentary quotations from the Senate Report to support their position. See Pet. 14-15. But, as the Third Circuit has pointed out, the language in the Conference Report "do[es not] * * * indicate that Congress intended to retain the 'exceptional circumstances' provision [of Subsection (b)(4)(A)], since that exception is not referred to in the Conference Report." *Sacred Heart*, 958 F.2d at 547 n.21.[5]

2. Petitioners also take issue (Pet. 17-21) with the court's alternative holding that, "[e]ven if we admit the possibility of other interpretations," the Secretary's interpretation is a "permissible" one that is entitled to prevail under *Chevron*. Petitioners argue that the Secretary's position is not entitled to deference because it is contrary to the policies underlying the statute and is an "about-face" (Pet. 19) from the Secretary's original administrative interpretation.

According to petitioners (Pet. 18), Congress meant for the Secretary to use "as close a proxy as reason-

---

[5] The Senate Report's passing reference to "various other exceptions and adjustments" (S. Rep. No. 23, 98th Cong., 1st Sess. 49 (1983), cited by petitioners (Pet. 5-6 n.6), does not aid petitioners. As noted above, the PPS legislation contained a number of explicit exceptions, none of which is claimed to apply in this case. There is no reason to believe that the "various other exceptions and adjustments" mentioned in the Senate Report referred to anything other than those express statutory provisions. The other language petitioners quote from the Senate Report (see Pet. 6 n.6) referred to an entirely different and unrelated subject, the allocation of non-physician services between Part A and Part B of the Medicare program. See S. Rep. No. 23, *supra*, at 50.

ably possible to actual allowable hospital-specific costs that would be incurred during the transition period." That is not what the PPS says. The PPS transition period provisions directed the Secretary to use "the hospital's target amount * * * as defined in subsection (b)(3)(A)." 42 U.S.C. 1395ww(d)(1)(A)(i)-(ii). As explained, Subsection (b)(3)(A) defines the "target amount" by reference to allowable costs during a pre-PPS base year, not (as petitioners would have it) allowable costs during the subsequent PPS transition period.

Petitioners similarly err in suggesting (Pet. 19) that the Secretary's current interpretation is a "litigation position" that conflicts with her original administrative interpretation. When the Secretary promulgated the original regulations implementing the PPS transition provisions, the regulations specified a limited number of situations in which the target amount could be modified to reflect costs other than allowable base year costs. The regulations did not, however, authorize modification of the target amount to take account of the kinds of "extraordinary circumstances" covered by Subsection (b)(4)(A). See 42 C.F.R. 412.71(b)-(c), 412.72(a). That exclusion from the Secretary's implementing regulations demonstrates that the Secretary's current position is consistent with the original administrative interpretation.

It is true, as petitioners note (Pet. 19), that the preamble to the original rulemaking referred to Subsection (b)(4)(A) as a source of authority for adjusting base-period costs during the PPS transition period. See 49 Fed. Reg. 234, 261 (1984). But the Secretary corrected that reference in a later rulemaking

proceeding—one on which petitioners themselves rely (Pet. 19-20 n.20). See 51 Fed. Reg. 8208, 8209 (1986). In the latter proceeding, the Secretary explained that the regulations allowing adjustments during the PPS transition period "were issued in accordance with [42 U.S.C.] section [1395ww](d)(5)(C)(iii)," the PPS's own discretionary-authority provision. 51 Fed. Reg. 8209 (1986).[6] The Secretary thus clarified that Subsection (b)(4)(A) was not a source of authority for adjustments during the PPS transition period. See *Sacred Heart*, 958 F.2d at 548.[7]

Petitioners note (Pet. 19-20) that two hospitals received adjustments during the PPS transition period on the basis of Subsection (b)(4)(A). Those two cases were erroneous departures from the Secretary's governing interpretation of the statute. See *Sacred Heart*, 958 F.2d at 548 n.24. The fact that two hospitals received adjustments that were unwarranted under the PPS legislation does not compromise the Secretary's subsequent, considered administrative interpretation of that legislation, particularly since that interpretation has governed every other

---

[6] The provision referred to in this *Federal Register* notice as 42 U.S.C. 1395ww(d)(5)(C)(iii) was later recodified as 42 U.S.C. 1395ww(d)(5)(I) (Supp. III 1991), without substantive change, in 1989. See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6003(e)(1)(A)(ii), 103 Stat. 2142.

[7] This Court has recognized that the "Secretary is not estopped from changing a view she believes to have been grounded upon a mistaken legal interpretation," and that courts should not approach statutory construction *de novo* simply because an administrative interpretation has evolved. *Good Samaritan Hosp.* v. *Shalala*, 113 S. Ct. 2151, 2161 (1993).

case arising during the PPS transition period, including this one.

In the end, it is academic whether the Secretary's interpretation of the statute is entitled to deference under *Chevron*. As the court of appeals recognized, the statutory provisions governing the PPS transition period create a precisely defined reimbursement calculus that simply does not incorporate Subsection (b)(4)(A). The statutory text alone thus refutes petitioners' position.

3. Petitioners urge (Pet. 10-11) the Court to grant certiorari to resolve a circuit conflict over the applicability of Subsection (b)(4)(A) during the PPS transition period. The D.C. Circuit's decision in this case and the Third Circuit's decision in *Sacred Heart* both hold that Subsection (b)(4)(A) did not apply during the transition period. In contrast, in *Community Hosp. of Chandler, Inc.* v. *Sullivan*, 963 F.2d 1206 (1992), the Ninth Circuit held— without the benefit of briefing by the Secretary[8]—that Subsection (b)(4)(A) did apply.[9]

---

[8] The Secretary did not brief the Subsection (b)(4)(A) issue in *Chandler* because the hospital had not raised that issue in the district court and therefore appeared to have waived it. Thus, it is not true that the Secretary's position in this case is "inconsistent * * * with the agency's position in *Chandler*" (Pet. 20). The Ninth Circuit chose to allow the hospital to raise the Subsection (b)(4)(A) issue for the first time on appeal, on the theory that the issue had been "constructively raised" when the hospital cited Subsection (b)(4)(A) (without arguing for its applicability) in the administrative and trial court proceedings. See *Chandler*, 963 F.2d at 1213.

[9] Petitioners assert (Pet. 10) that the decisions of "[n]umerous district courts" support their position. However, all but two of the decisions relied upon by petitioners (Pet. 11 n.13)

Despite the fact that the Ninth Circuit's decision conflicted with the Third Circuit's earlier decision in *Sacred Heart*, the government chose not to seek certiorari in *Chandler* because of the limited significance of the Subsection (b)(4)(A) issue. The legal controversy concerns an interim Medicare reimbursement scheme that expired more than five years ago. Review by this Court would have no significance for reimbursement in future Medicare cost reporting periods. Furthermore, only a limited number of reimbursement claims that involve the applicability of Subsection (b)(4)(A) during the PPS transition period remain pending. Even as to those claims, the significance of the issue is speculative. By its own terms, Subsection (b)(4)(A) affects only those exceptional cases where hospitals claim that "events beyond [their] control or extraordinary circumstances" distorted their costs. Even where Subsection (b)(4)(A) is invoked, it by no means follows that the resolution of the issue petitioners raise would affect the ultimate outcome of the reimbursement dispute. In this case, for example, the district court assumed that Subsection (b)(4)(A) did apply during the PPS transition period, but nonetheless ruled against petitioners, on the ground that they had-

---

were rendered by the District Court for the District of Columbia, and have now been superseded by the decision of the court of appeals in this case. See *Methodist Hosp.* v. *Shalala*, 6 F.3d 829 (D.C. Cir. 1993) (unpublished order) (reversing *Methodist Hosp.* v. *Sullivan*, C.A. No. 90-1871-GAG (D.D.C. Sept. 20, 1991) (cited at Pet. 11 n.13)). Also, since the filing of the certiorari petition, the Secretary has prevailed in *Hillsborough County Hosp. Auth.* v. *Shalala*, No. 91-12-CIV-T-21B (M.D. Fla. Nov. 9, 1993), cited by petitioners (Pet. 11).

failed to show the kind of "events beyond the hospital's control or extraordinary circumstances" that Subsection (b)(4)(A) requires. Pet. App. 16a-23a.

For the same reasons that the government declined to seek review in *Chandler*, review also is unwarranted in this case. While a circuit conflict exists, now as it did then, the conflict lacks the practical significance necessary to warrant resolution by this Court.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

DREW S. DAYS, III
Solicitor General

FRANK W. HUNGER
Assistant Attorney General

ANTHONY J. STEINMEYER
SCOTT R. MCINTOSH
Attorneys

DECEMBER 1993